

2.02.32 Leadless Cardiac Pacemakers			
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## Policy Statement

- I. The Micra™ VR or Aveir™ (see Policy Guidelines) single-chamber transcatheter pacing system may be considered **medically necessary** in individuals when **both** conditions below are met:
  - A. The individual has high-grade atrioventricular (AV) block (see Policy Guidelines) in the presence of atrial fibrillation or has significant bradycardia and:
    1. Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines)
    2. Chronic atrial fibrillation
    3. Severe physical disability (see Policy Guidelines)
  - B. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as **any** of the following:
    1. History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection (see Policy Guidelines)
    2. Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis
    3. Presence of a bioprosthetic tricuspid valve
- II. The Micra™ AV single-chamber transcatheter pacing system may be considered **medically necessary** in individuals when **both** conditions below are met:
  - A. The individual has high-grade AV block (see Policy Guidelines) in the presence of atrial fibrillation or has significant bradycardia and:
    1. Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines)
    2. Chronic atrial fibrillation
    3. Severe physical disability (see Policy Guidelines)
    4. There is an indication for VDD pacing and the individual may benefit from maintenance of AV synchronous ventricular pacing (see Policy Guidelines)
  - B. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as **any** of the following:
    1. History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection (see Policy Guidelines)
    2. Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis
    3. Presence of a bioprosthetic tricuspid valve
- III. The Micra™ and Aveir™ single-chamber transcatheter pacing systems are considered **investigational** in all other situations in which the above criteria are not met.
- IV. The Aveir™ DR dual-chamber pacing system is considered **investigational**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

## Policy Guidelines

Policy criteria are informed by U.S. Food and Drug Administration (FDA) labeled indications for use and clinical input.

### Physical Disability and Infection Risk

Clinical input suggests that severe physical disability encompasses a variety of comorbidities where conventional pacemaker placement would confer undue short- or long-term risk or further compromise a limited ability to meet activities of daily living, including compliance with postoperative care instructions. Examples include individuals with short expected lifespan, individuals with end-stage heart, lung, neurologic, or skeletal conditions, and individuals with mental health or developmental challenges.

The 2019 European Heart Rhythm Association (EHRA) international consensus paper on the prevention, diagnosis, and treatment of cardiac implantable electronic device (CIED) infections has been endorsed by the Heart Rhythm Society (HRS) and lists the following non-modifiable patient-related risk factors for CIED infections:

- End-stage renal disease
- Corticosteroid use
- Renal failure
- History of device infection
- Chronic obstructive pulmonary disease
- Heart failure (New York Heart Association [NYHA] Class  $\geq$  II)
- Malignancy
- Diabetes mellitus

### Device Contraindications

As per the FDA label, the Aveir™ Leadless Pacemaker Models LSP112V, LSP201A, and LSP202V are contraindicated in the following situations:

- Use of any pacemaker is contraindicated in individuals with a co-implanted implantable cardioverter-defibrillator because high-voltage shocks could damage the pacemaker and the pacemaker could reduce shock effectiveness.
- Single-chamber ventricular demand pacing is relatively contraindicated in individuals who have demonstrated pacemaker syndrome, have retrograde ventriculoatrial conduction, or suffer a drop in arterial blood pressure with the onset of ventricular pacing.
- Programming of rate-responsive pacing is contraindicated in individuals with intolerance of high sensor-driven rates.
- Use is contraindicated in individuals with an implanted vena cava filter or mechanical tricuspid valve because of interference between these devices and the delivery system during implantation.
- Individuals with known history of allergies to any of the components of this device may suffer an allergic reaction to this device. Prior to use, the recipient should be counseled on the materials contained in the device and a thorough history of allergies must be discussed.

The Aveir™ Leadless Pacemaker is conditionally safe for use in the magnetic resonance imaging (MRI) environment when used according to the instructions in the MRI-Ready Leadless System Manual (which includes equipment settings, scanning procedures, and a listing of conditionally approved components). Scanning under different conditions may result in severe patient injury, death, or device malfunction.

As per the FDA label, the Micra Model MC1VR01 (Micra VR) and Model MC1AVR1 (Micra AV) pacemakers are contraindicated for individuals who have the following types of devices implanted:

- An implanted device that would interfere with the implant of the Micra device in the judgment of the implanting provider
- An implanted inferior vena cava filter
- A mechanical tricuspid valve
- An implanted cardiac device providing active cardiac therapy which may interfere with the sensing performance of the Micra device

As per the FDA label, the Micra Model MC1VR01 and Model MC1AVR1 pacemakers are also contraindicated for individuals who have the following conditions:

- Femoral venous anatomy unable to accommodate a 7.8 mm (23 French) introducer sheath or implant on the right side of the heart (for example, due to obstructions or severe tortuosity)
- Morbid obesity that prevents the implanted device to obtain telemetry communication within less than 12.5 cm (4.9 in)
- Known intolerance to titanium, titanium nitride, parylene C, primer for parylene C, polyether ether ketone, siloxane, nitinol, platinum, iridium, liquid silicone rubber, silicone medical adhesive, and heparin or sensitivity to contrast medical which cannot be adequately premedicated

As per the FDA label, Micra pacemakers should not be used in individuals for whom a single dose of 1.0 mg dexamethasone acetate cannot be tolerated because the device contains a molded and cured mixture of dexamethasone acetate with the target dosage of 272 µg dexamethasone acetate. It is intended to deliver the steroid to reduce inflammation and fibrosis.

For the MRI contraindications for individuals with a Micra MRI device, refer to the Medtronic MRI Technical Manual.

As per the FDA label, some individuals will not benefit from the AV synchronous (VDD) mode supported by the Micra Model MC1AVR1 pacemaker. Individuals with the following conditions should instead be considered for a dual-chamber transvenous pacing system:

- Sinus node dysfunction;
- High sinus rates requiring atrial tracking;
- Weak atrial contraction;
- Symptoms during loss of atrioventricular (AV) synchrony;
- Frequent premature atrial or ventricular contractions.

### High-Grade Atrioventricular Block

Atrioventricular block occurs when there is interference of the electrical signals from the atrium to the ventricle and is categorized based on severity. First degree AV block occurs when signals are transferred more slowly than normal. Second-degree AV block is divided into Type I and Type II. Type I is also called Mobitz Type I or Wenckebach's AV block. There is gradually slower activity which may produce skipped heartbeats. Second-degree Type II is also called Mobitz Type II where more signals fail to reach the ventricles, resulting in a slower and more abnormal heart rhythm. Second-degree AV block can be paroxysmal (not persistent) or permanent. Additionally, high-degree AV block is a form of second-degree AV block in which the conduction ratio is high representing multiple atrial contractions that are not conducting to the ventricle; however, there is still some AV conduction and as such is not a third-degree AV block. Third-degree AV block is a complete block of the electrical signals; while the ventricles contract on their own, the consequences are reduced and irregular heart rate and reduced cardiac output.

Individuals with rare episodes of AV block or sinus arrest generally do not require pacing intervention, although symptomatic individuals might have significant need for pacing. The Micra™ VR and Aveir™ devices are indicated when there is infrequent AV block. The Micra™ AV device is indicated with infrequent or chronic AV block. These definitions come from the intended use definitions of the

devices and clinical input. Note that there is no strict definition of the frequency of episodes or the degree of symptoms.

### **VDD Pacing**

VDD pacing is a pacing mode used in pacemakers whereby sensing occurs in both the atrium and ventricle, with pacing only occurring in the ventricle. The first letter (V) indicates that the Ventricle is the pacing chamber, the second letter (D) indicates that both the atrium and ventricle are the sensing chambers, and the third letter (D) indicates that the mode of operation is dual (inhibited and triggered). Uses of VDD pacing include pacemaker syndrome where there is reduced coordination between the atrial and ventricular contractions resulting in lower cardiac output, and when individuals with an implant have complete AV block with preserved sinus functioning. VDD is used in dual chamber transvenous pacemakers and in single-chamber ventricular pacemakers with leads that float in the atrium for sensing. The Micra™ AV leadless pacemaker supports VDD pacing.

### **Atrioventricular Synchrony**

Devices that support maintenance of AV synchrony can sense atrial electrical activity and pace the ventricular chamber accordingly. Pacemakers maintaining AV synchrony may lead to less morbidity and mortality than ventricular stimulation alone and reduce the risk of pacemaker syndrome. The Micra™ AV device provides AV synchronous ventricular pacing similar to a transvenous VDD system. The implanted device depends on the appropriate sensing of atrial mechanical signals to achieve AV synchrony. The level of AV synchrony may vary in individual recipients and may not be predictable prior to implant. The manufacturer cautions that loss of AV synchrony can be caused by the interference of mechanical vibrations stemming from various activities and environments.

### **Pacemaker Syndrome**

In pacemaker syndrome there is reduced coordination between atrial contraction and ventricular contraction, resulting in reduced cardiac output. The syndrome is most commonly seen in the setting of a single-chamber ventricular pacemaker with ventricular sensing and pacing, as with no atrial sensing the ventricles contract at the programmed rate independently from atrial contraction.

### **Device Retrieval and Replacement**

Leadless pacemakers have a limited lifespan. Removal of devices can be complicated by encapsulation due to fibrosis. Devices can instead be deactivated and remain in place, with another device implanted. Use of deactivated and activated devices might result in electromagnetic interference. Based on bench testing, the current recommendation for device end of service care includes adding a replacement device with or without explantation of the deactivated implant. Explantation of the deactivated implant should be performed by a clinician with expertise in the removal of implanted leads. Use of co-implanted deactivated and activated devices has not been clinically tested, and as such Plans will need to consider the medical necessity of repeat implantation. The Aveir™ device features helix-based active fixation designed to facilitate device removal with a dedicated retrieval catheter; however, limited data are available on retrieval success rates.

### **Mechanical Interference**

For axillary transvenous pacemakers, there is a concern that leads or the generator could be impacted by the recoil of using a firearm (e.g., rifles or shotguns). Thus leadless cardiac pacemakers can provide an alternative for individuals who suffer lead fracture or malfunction from mechanical stress and may be considered when axillary venous access is present only on a side of the body that would not allow use of equipment producing such mechanical stress (e.g., a firearm).

### **Coding**

See the [Codes table](#) for details.

## Description

Pacemakers are intended to be used as a substitute for the heart's intrinsic pacing system to correct cardiac rhythm disorders. Conventional pacemakers consist of 2 components: a pulse generator and electrodes (or leads). Pacemakers are considered life-sustaining, life-supporting class III devices for individuals with a variety of bradyarrhythmias. Even though the efficacy and safety profile of conventional pacemakers are excellent, in a small proportion of individuals, they may result in lead complications and the requirement for a surgical pocket. Further, some individuals are medically ineligible for conventional pacemakers due to lack of venous access and recurrent infection. Leadless pacemakers are single-unit devices that are implanted in the heart via femoral access, thereby eliminating the potential for complications as a result of leads and surgical pocket. The Micra and Aveir single-chamber transcatheter pacing systems and the Aveir dual-chamber pacing system are the only commercially available leadless pacemakers in the U.S. approved by the U.S. Food and Drug Administration.

### Summary of Evidence

For individuals with a guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system who receive a single-chamber transcatheter pacing system, the evidence includes a systematic review, pivotal prospective cohort studies, a postapproval prospective cohort study, a Medicare registry, and a retrospective US Food and Drug Administration (FDA) database analysis. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Results at 6 months and 1 year for the Micra pivotal study reported high procedural success (>99%) and device effectiveness (pacing capture threshold met in 98% of patients). Most of the system- or procedure-related complications occurred within 30 days. At 1 year, the incidence of major complications did not increase substantially from 6 months (3.5% at 6 months vs. 4% at 1 year). Results of the Micra postapproval study were consistent with the pivotal study and showed a lower incidence of major complications up to 30 days postimplantation as well as 1 year (1.5% and 2.7%, respectively). In both studies, the point estimates of major complications were lower than the pooled estimates from 6 studies of conventional pacemakers used as a historical comparator. While Micra device eliminates lead- and surgical pocket-related complications, its use can result in potentially more serious complications related to implantation and release of the device (traumatic cardiac injury) and less serious complications related to the femoral access site (groin hematomas, access site bleeding). Initial data from a Medicare registry found a significantly higher rate of pericardial effusion and/or perforation within 30 days in patients with the leadless Micra pacemaker compared to patients who received a transvenous device; however, overall 6-month complication rates were significantly lower in the Micra group in the adjusted analysis ( $p=.02$ ). In a real-world study of Medicare patients, the Micra device was associated with a 41% lower rate of reinterventions and a 32% lower rate of chronic complications compared with transvenous pacing, with no significant difference in adjusted all-cause mortality at 3 years despite the higher comorbidity index for patients implanted with a Micra device. However, patients receiving the Micra device experienced significantly more other complications, driven by higher rates of pericarditis. No significant differences were noted in the composite endpoint of time to heart failure hospitalization or death for the full cohort ( $p=.28$ ) or the subgroup without a history of heart failure ( $p=.98$ ). It is also unclear whether all patients were considered medically eligible for a conventional pacing system. A single-arm study of the Micra AV device reported that 85.2% of individuals with complete atrioventricular (AV) block and normal sinus rhythm successfully achieved a >70% resting AV synchrony (AVS) rate at 1 month postimplant and that AVS rates could be further enhanced with additional device programming. However, clinically meaningful rates of AVS are unknown. Longer-term device characterization is planned in the Micra AV Post-Approval Registry through 3 years. The Aveir pivotal prospective cohort study primary safety and efficacy outcomes at 6 weeks exceeded performance goals for complication-free rate and composite success rate (96.0% and 95.9%, respectively). Results at 6 months were similar and at 1 year were 93.2% and 91.5%, respectively. Incidence of major complications at 1 year was 6.7% compared to 4.0% in the Micra pivotal trial. The 2-year survival estimate of 85.3% is based on Phase 1 performance with the predecessor Nanostim

device. Considerable uncertainties and unknowns remain in terms of the durability of the devices and device end-of-life issues. Early and limited experience with the Micra device has suggested that retrieval of these devices is unlikely because in due course, the device will be encapsulated. There are limited data on device-device interactions (both electrical and mechanical), which may occur when there is a deactivated Micra device alongside another leadless pacemaker or when a leadless pacemaker and transvenous device are both present. Although the Aveir device is specifically designed to be retrieved when therapy needs evolve or the device needs to be replaced, limited data are available on retrieval outcomes. While the current evidence is encouraging, overall benefit with the broad use of FDA-approved single-chamber transcatheter pacing systems compared with conventional pacemakers has not been shown. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a single-chamber transcatheter pacing system, the evidence includes subgroup analysis of a pivotal prospective cohort study and a postapproval prospective cohort study for the Micra device. It is unclear whether the Aveir pivotal study enrolled patients medically ineligible for a conventional pacing system. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Information on the outcomes in the subgroup of patients from the postapproval study showed that the Micra device was successfully implanted in 98% to 99% of cases, and safety outcomes were similar to the original cohort. Even though the evidence is limited and long-term effectiveness and safety are unknown, the short-term benefits may outweigh the risks because the complex trade-off of adverse events for these devices needs to be assessed in the context of the life-saving potential of pacing systems for patients ineligible for conventional pacing systems. There are little data available regarding outcomes associated with other alternatives to conventional pacemaker systems such as epicardial leads or transiliac placement. Epicardial leads are most relevant for the patient who is already going to have a thoracotomy for treatment of their underlying condition (e.g., congenital heart disease). Epicardial leads are associated with a longer intensive care unit stay, more blood loss, and longer ventilation times compared to conventional pacemaker systems. The evidence for transiliac placement is limited to small case series and the incidence of atrial lead dislodgement using this approach in the literature ranged from 7% to 21%. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a dual-chamber pacing system who are medically eligible for a conventional pacing system who receive a dual-chamber leadless pacing system, the evidence includes a pivotal prospective single cohort study. Relevant outcomes are freedom from complications and adequate atrial capture threshold and sensing amplitude. Results from 3 months and 6 months of the pivotal study reported freedom from complications in 90.3% and 89.1% of individuals, respectively, and adequate atrial capture threshold and sensing amplitude in 90.2% and 90.8% of individuals, respectively. Acute and long-term events will be captured in a post approval study through 9 years. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a dual-chamber pacing system who are medically ineligible for a conventional pacing system who receive a dual-chamber leadless pacing system, no evidence was identified that exclusively enrolled individuals who were medically ineligible for a conventional pacing system. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

## **Additional Information**

### **2023 Input**

Clinical input was sought to help determine whether the use of an Aveir or Micra AV transcatheter pacing system for an individual with a guidelines-based indication for a ventricular pacing system would provide a clinically meaningful improvement in net health outcome and whether the use is

consistent with generally accepted medical practice depending on individual medical eligibility for a conventional pacing system. In response to requests, clinical input was received from 2 respondents, including 1 specialty society-level response including physicians with academic medical center affiliation and 1 physician-level response with academic affiliation identified through a specialty society.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a Micra AV or Aveir transcatheter pacing system, clinical input supports this use provides a clinically meaningful improvement in net health outcomes and indicates this use is consistent with generally accepted medical practice in a subgroup of appropriately selected individuals when both conditions below are met:

- The individual has significant bradycardia and:
  - Normal sinus rhythm with rare episodes of 2° or 3° atrioventricular (AV) block or sinus arrest and severe physical disability or short expected lifespan; OR
  - Chronic atrial fibrillation.
- The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:
  - History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection;
  - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins, or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis;
  - Presence of a bioprosthetic tricuspid valve.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system who receive a Micra AV or Aveir transcatheter pacing system, clinical input indicates this use is consistent with generally accepted medical practice but reports mixed support that this use provides a clinically meaningful improvement in net health outcomes.

Further details from clinical input are included in the Appendix.

### 2019 Input

Clinical input was sought to help determine whether the use of leadless cardiac pacemakers for individuals with a guidelines-based indication for a ventricular pacing system would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input was received from 2 respondents, including 1 specialty society-level response and 1 physician-level response identified through specialty societies including physicians with academic medical center affiliations.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a Micra transcatheter pacing system, clinical input supports this use provides a clinically meaningful improvement in net health outcomes and indicates this use is consistent with generally accepted medical practice in a subgroup of appropriately selected individuals when both conditions below are met:

- The individual has symptomatic paroxysmal or permanent high-grade arteriovenous block or symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses).
- The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:
  - History of an endovascular or CIED infection or who are very high-risk for infection
  - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis

- Presence of a bioprosthetic tricuspid valve

Further details from clinical input are included in the Appendix.

### Related Policies

- N/A

### Benefit Application

Benefit determinations should be based in all cases on the applicable member health services contract language. To the extent there are conflicts between this Medical Policy and the member health services contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal law may prohibit health plans from denying FDA-approved Healthcare Services as investigational or experimental. In these instances, Blue Shield of California may be obligated to determine if these FDA-approved Healthcare Services are Medically Necessary.

### Regulatory Status

In April 2016, the Micra transcatheter pacing system (Medtronic) was approved by the FDA through the premarket approval (PMA) process (PMA number: P150033) for use in patients who have experienced 1 or more of the following conditions:

- symptomatic paroxysmal or permanent high-grade arteriovenous block in the presence of atrial fibrillation
- paroxysmal or permanent high-grade arteriovenous block in the absence of atrial fibrillation, as an alternative to dual-chamber pacing, when atrial lead placement is considered difficult, high-risk, or not deemed necessary for effective therapy
- symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses), as an alternative to atrial or dual-chamber pacing, when atrial lead placement is considered difficult, high-risk, or not deemed necessary for effective therapy.

In January 2020, the Micra AV Transcatheter Pacing System Model MCI1AVR1 and Application Software Model SW044 were approved as a PMA supplement (S061) to the Micra system described above. The Micra AV includes an enhanced algorithm to provide AV synchronous pacing. In November 2021, the FDA issued a letter to health care providers regarding the risk of major complications related to cardiac perforation during implantation of leadless pacing systems.<sup>31</sup> Specifically, the FDA states that "real-world use suggests that cardiac perforations associated with Micra leadless pacemakers are more likely to be associated with serious complications, such as cardiac tamponade or death, than with traditional pacemakers." This letter has been removed from the FDA website as of April 2024.

In March 2022, the Aveir VR Leadless Pacemaker was approved by the FDA through the premarket approval process (PMA number: P150035) for use in individuals with bradycardia and:

- normal sinus rhythm with only rare episodes of atrioventricular block or sinus arrest;
- chronic atrial fibrillation;
- severe physical disability.

Rate-Modulated Pacing is indicated for individuals with chronotropic incompetence, and for those who would benefit from increased stimulation rates concurrent with physical activity.

In June 2023, a premarket approval application supplement with expanded indications to include dual-chamber pacing with the AveirDR Leadless System was approved by the FDA (PMA number: P150035) for use in individuals with 1 or more of the following permanent conditions:

- Syncope;
- Pre-syncope;
- Fatigue;
- Disorientation.

Rate-Modulated Pacing is indicated for individuals with chronotropic incompetence, and for those who would benefit from increased stimulation rates concurrent with physical activity.

Dual-Chamber Pacing is indicated for individuals exhibiting:

- Sick sinus syndrome;
- Chronic, symptomatic second- and third-degree atrioventricular block;
- Recurrent Adams-Stokes syndrome;
- Symptomatic bilateral bundle branch block when tachyarrhythmia and other causes have been ruled out.

## Rationale

### Background

#### Conventional Pacemakers

Pacemakers are intended to be used as a substitute for the heart's intrinsic pacing system to correct cardiac rhythm disorders. By providing an appropriate heart rate and heart rate response, cardiac pacemakers can reestablish effective circulation and more normal hemodynamics that are compromised by a slow heart rate. Pacemakers vary in system complexity and can have multiple functions as a result of the ability to sense and/or stimulate both the atria and the ventricles.

Transvenous pacemakers or pacemakers with leads (hereinafter referred to as conventional pacemakers) consist of 2 components: a pulse generator (i.e., battery component) and electrodes (i.e., leads). The pulse generator consists of a power supply and electronics that can provide periodic electrical pulses to stimulate the heart. The generator is commonly implanted in the infraclavicular region of the anterior chest wall and placed in a pre-pectoral position; in some cases, a subpectoral position is advantageous. The unit generates an electrical impulse, which is transmitted to the myocardium via the electrodes affixed to the myocardium to sense and pace the heart as needed.

Conventional pacemakers are also referred to as single-chamber or dual-chamber systems. In single-chamber systems, only 1 lead is placed, typically in the right ventricle. In dual-chamber pacemakers, 2 leads are placed – 1 in the right atrium and the other in the right ventricle. Single-chamber ventricular pacemakers are more common.

Annually, approximately 200,000 pacemakers are implanted in the U.S. and 1 million worldwide.<sup>1</sup> Implantable pacemakers are considered life-sustaining, life-supporting class III devices for patients with a variety of bradyarrhythmias. Pacemaker systems have matured over the years with well-established, acceptable performance standards. As per the U.S. Food and Drug Administration (FDA), the early performance of conventional pacemaker systems from implantation through 60 to 90 days have usually demonstrated acceptable pacing capture thresholds and sensing. Intermediate performance (90 days through more than 5 years) has usually demonstrated the reliability of the pulse generator and lead technology. Chronic performance (5 to 10 years) includes a predictable decline in battery life and mechanical reliability, but a vast majority of patients receive excellent pacing and sensing free of operative or mechanical reliability failures.

Even though the safety profile of conventional pacemakers is excellent, they are associated with complications particularly related to leads. Most safety data on the use of conventional pacemakers come from registries from Europe, particularly from Denmark where all pacemaker implants are recorded in a national registry. These data are summarized in Table 1. It is important to recognize that valid comparison of complication rates is limited by differences in definitions of complications, which results in a wide variance of outcomes, as well as by the large variance in follow-up times, use of single-chamber or dual-chamber systems, and data reported over more than 2 decades.<sup>2</sup> As such, the following data are contemporary and limited to single-chamber systems when reported separately.

In many cases when a conventional pectoral approach is not possible, alternative approaches such as epicardial pacemaker implantation and trans-iliac approaches have been used.<sup>3</sup> Cohen et al (2001) reported outcomes from a retrospective analysis of 123 patients who underwent 207 epicardial lead implantations.<sup>4</sup> Congenital heart disease was present in 103 (84%) of the patients. Epicardial leads were followed for 29 months (range, 1 to 207 months). Lead failure was defined as the need for replacement or abandonment due to pacing or sensing problems, lead fracture, or phrenic/muscle stimulation. The 1-, 2-, and 5-year lead survival was 96%, 90%, and 74%, respectively. Epicardial lead survival in those placed by a subxiphoid approach was 100% at 1 year and at 10 years, by the sternotomy approach (93.9% at 1 year and 75.9% at 10 years) and lateral thoracotomy approach (94.1% at 1 year and 62.4% at 10 years).

Doll et al (2008) reported results of a randomized controlled trial comparing epicardial implantation versus conventional pacemaker implantation in 80 patients with indications for cardiac resynchronization therapy.<sup>5</sup> The authors reported that the conventional pacemaker group had a significantly shorter intensive care unit stay, less blood loss, and shorter ventilation times while the epicardial group had less exposure to radiation and less use of contrast medium. The left ventricular pacing threshold was similar in the 2 groups at discharge but longer in the epicardial group during follow-up. Adverse events were also similar in the 2 groups. The following events were experienced by 1 (3%) patient each in the epicardial group: pleural puncture, pneumothorax, wound infection, acute respiratory distress syndrome, and hospital mortality.

As a less invasive alternative to the epicardial approach, the trans-iliac approach has also been utilized. Data using trans-iliac approach is limited. Multiple other studies with smaller sample size report a wide range of lead longevity.

Harake et al (2018) reported a retrospective analysis of 5 patients who underwent a transvenous iliac approach (median age, 26.9 years).<sup>6</sup> Pacing indications included AV block in 3 patients and sinus node dysfunction in 2 patients. After a median follow-up of 4.1 years (range, 1.0 to 16.7 years), outcomes were reported for 4 patients. One patient underwent device revision for lead position-related groin discomfort; a second patient developed atrial lead failure following a Maze operation and underwent lead replacement by the iliac approach. One patient underwent heart transplantation 6 months after implant with only partial resolution of pacing-induced cardiomyopathy. Tsutsumi et al (2010) reported a case series of 4 patients from Japan in whom conventional pectoral approach was precluded due to recurrent lead infections (n=1), superior vena cava obstruction following cardiac surgery (n=2) and a postoperative dermal scar (n=1). The mean follow-up was 24 months and the authors concluded the iliac vein approach was satisfactory and less invasive alternative to epicardial lead implantation. However, the authors reported that the incidence of atrial lead dislodgement using this approach in the literature ranged from 7% to 21%. Experts who provided clinical input reported that trans-iliac or surgical epicardial approach requires special expertise and long-term performance is suboptimal.<sup>7</sup>

**Table 1. Reported Complication Rates with Conventional Pacemakers**

Complications	Rates, % <sup>8,9,10,a</sup>
Traumatic complications	

Complications	Rates, % <sup>8,9,10,a</sup>
RV perforation	0.2 to 0.8
RV perforation with tamponade	0.07 to 0.4
Pneumo(hemo)thorax	0.7 to 2.2
Pocket complications	
Including all hematomas, difficult to control bleeding, infection, discomfort, skin erosion	4.75
Including only those requiring invasive correction or reoperation	0.66 to 1.0
Lead-related complications	
Including lead fracture, dislodgement, insulation problem, infection, stimulation threshold problem, diaphragm or pocket stimulation, other	1.6 to 3.8
All system-related infections requiring reoperation or extraction	0.5 to 0.7

Adapted from U.S. Food and Drug Administration executive summary memorandum (2016).<sup>11</sup>.

<sup>a</sup> Rates are for new implants only and ventricular single-chamber devices when data were available. Some rates listed in this column are for single- and dual-chamber devices when data were not separated in the publication.

Note that Micra transcatheter pacing system is a single-chamber device.

RV: right ventricle.

### Potential Advantages of Leadless Cardiac Pacemakers Over Conventional Pacemakers

The potential advantages of leadless pacemakers fall into 3 categories: avoidance of risks associated with intravascular leads in conventional pacemakers, avoidance of risks associated with pocket creation for placement of conventional pacemakers, and an additional option for patients who require a single-chamber pacer.<sup>12</sup>

Lead complications include lead failure, lead fracture, insulation defect, pneumothorax, infections requiring lead extractions and replacements that can result in a torn subclavian vein or the tricuspid valve. In addition, there are risks of venous thrombosis and occlusion of the subclavian system from the leads. Use of a leadless system eliminates such risks with the added advantage that a patient has vascular access preserved for other medical conditions (e.g., dialysis, chemotherapy).

Pocket complications include infections, erosions, and pain that can be eliminated with leadless pacemakers. Further, a leadless cardiac pacemaker may be more comfortable and appealing because unlike conventional pacemakers, patients are unable to see or feel the device or have an implant scar on the chest wall.

Leadless pacemakers may also be a better option than surgical endocardial pacemakers for patients with no vascular access due to renal failure or congenital heart disease.

### Atrioventricular Synchrony

The Micra AV device supports maintenance of atrioventricular (AV) synchrony by sensing atrial mechanical contraction (A4 signal). Several small-cohort studies have investigated the relationship between parameters (e.g., clinical and echocardiographic) and A4 signal amplitude. Briongos-Figuero et al (2023) investigated clinical and echocardiographic predictors of optimal AV synchrony, defined as  $\geq 85\%$  of total cardiac cycles being synchronous, in individuals with successful Micra AV implant (N=43). The authors performed univariate analyses followed by multivariate analysis. They found diabetes and chronic obstructive pulmonary disease to be associated with A4 signal amplitude, however no echocardiographic parameters were associated with A4 signal amplitude.<sup>13</sup> Troisi et al (2024) studied the relationship between echocardiographic parameters and A4 signal amplitude in individuals implanted with Micra AV (N=21). The authors concluded echocardiographic parameters, particularly related to left atrial function, may be related to successful AV synchrony.<sup>14</sup> Kawatani et al (2024) et al studied predictors of AV synchrony in individuals with Micra AV implants (N=50). Participants were stratified into 2 groups, high and low A4 amplitude. In a multivariate analysis, maximum deflection index was the only parameter associated with low A4 amplitude.<sup>15</sup> These studies were exploratory and results among the studies were inclusive. More research in larger cohort studies is needed to produce more conclusive evidence on parameters that are predictive of AV synchrony.

### Battery Life and Device Retrieval

Currently, real-world evidence of long-term battery life for leadless pacemakers is limited. Breeman et al (2023) studied the battery life of the Micra VR after implantation (N=153). The manufacturer's predicted battery life for the Micra VR is 12 years. Using mixed models to assess changes in electrical parameters over time, the authors concluded that for a majority of individuals the expected battery longevity is >8 years.<sup>16</sup> Due to the limited lifespan of leadless pacemakers, they are designed to be retrievable (e.g., the helix fixation design of the Aveir devices). However, evidence on the safety and success of device retrieval is limited to case reports.<sup>17,18,19</sup>

### Anatomical Placement

Li et al (2023) studied different anatomical placements in the ventricular septum of the Micra VR (N=15) and found no impact on safety or electrical characteristics of the device.<sup>20</sup> In a large cohort study in individuals with Micra AV or Micra VR implants (N=358) by Shantha et al (2023), the authors found apical septum placement was associated with a higher risk of pacing-induced cardiomyopathy compared to mid/high septum placement.<sup>21</sup> Larger randomized studies are needed to confirm how anatomical placement of the device impacts safety and effectiveness.

### Leadless Cardiac Pacemakers in Clinical Development

Leadless pacemakers are self-contained in a hermetically sealed capsule. The capsule houses a battery and electronics to operate the system. Similar to most pacing leads, the tip of the capsule includes a fixation mechanism and a monolithic controlled-release device. The controlled-release device elutes a glucocorticosteroid to reduce acute inflammation at the implantation site. Leadless pacemakers have rate-responsive functionality, and current device longevity estimates are based on bench data. Estimates have suggested that these devices may last over 10 years, depending on the programmed parameters.<sup>11</sup>

Four systems are currently being evaluated in clinical trials: (1) the Micra Transcatheter Pacing System (Medtronic), (2) the Aveir VR Leadless Pacemaker (Abbott; formerly Nanostim, St. Jude Medical); (3) the Aveir DR Dual Chamber Leadless Pacemaker System (Abbott); and (4) the WiCS Wireless Cardiac Stimulation System (EBR Systems). The first 3 devices are free-standing capsule-sized devices that are delivered via femoral venous access using a steerable delivery sheath. However, the fixing mechanism differs between the Micra and Aveir devices. In the Micra Transcatheter Pacing System, the fixation system consists of 4 self-expanding nitinol tines, which anchor into the myocardium; for the Aveir devices, there is a screw-in helix that penetrates into the myocardium. In the Micra and Aveir devices, the cathode is steroid eluting and delivers pacing current; the anode is located in a titanium case. The fourth device, WiCS system differs from the other devices; this system requires implanting a pulse generator subcutaneously near the heart, which then wirelessly transmits ultrasound energy to a receiver electrode implanted in the left ventricle. The receiver electrode converts the ultrasound energy and delivers electrical stimulation to the heart sufficient to pace the left ventricle synchronously with the right.<sup>11</sup>

Of these 4, only the Micra and Aveir single-chamber transcatheter pacing systems and the Aveir dual-chamber transcatheter pacing system are approved by the FDA and commercially available in the U.S. Multiple clinical studies of the Aveir predecessor device, Nanostim, have been published<sup>1,22,23,24,25,25,26</sup>, but trials have been halted due to the migration of the docking button in the device and premature battery depletion. These issues have since been addressed with the Aveir device.<sup>27</sup>

The Micra is about 25.9 mm in length and introduced using a 23 French catheter via the femoral vein to the right ventricle. It weighs about 1.75 grams and has an accelerometer-based rate response.<sup>28</sup> The Aveir VR is about 42 mm in length and introduced using a 25 French catheter to the right ventricle. It also weighs about 3 grams and uses a temperature-based rate response sensor.<sup>29</sup>

The atrial Aveir DR is about 32.3 mm in length and weighs about 2.1 grams. The ventricular Aveir DR is about 38.0 mm in length and weighs about 2.4 grams. Both are introduced using a 25 French catheter. The system uses a temperature-based rate response.<sup>30</sup>

### **Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Conventional pacemaker systems have been in use for over 50 years and current technology has matured with significant similarities in designs across models. Extensive bench testing data with conventional pacemakers and a good understanding of operative and early postimplant safety and effectiveness are available, which limits the need for clinical data collection to understand their safety and effectiveness with regard to implantation, tip fixation, electrical measures, and rate response. As such, an RCT comparing the leadless pacemakers with conventional pacemakers was not required by the U.S. Food and Drug Administration (FDA).

### **Ventricular Pacing for Individuals Who are Medically Eligible for a Conventional Pacing System Clinical Context and Therapy Purpose**

The purpose of single-chamber transcatheter pacing systems in individuals with a class I or II guidelines-based indication for implantation of a single-chamber ventricular pacemaker is to provide a treatment option that is an alternative to or an improvement on conventional pacing systems.

The following PICO was used to select literature to inform this review.

### **Populations**

The relevant population of interest is individuals with a class I or II guidelines-based indication for implantation of a single-chamber ventricular pacemaker who are medically eligible to receive conventional pacing system.

### ***Interventions***

The therapy being considered is a single-chamber transcatheter pacing system. The Micra and Aveir devices are single-chamber, ventricular pacemakers implanted through a femoral vein by advancing a delivery catheter into the right ventricle and affixing the device in the myocardium.

Micra has a programmable mode to deactivate pacing and sensing at the end of the life of the device and may remain in the body indefinitely after deactivation. The device also has a retrieval feature at the proximal end for percutaneous snare retrieval and removal.

Aveir has a unique mapping capability to assess correct positioning prior to placement and is specifically designed to be retrieved when therapy needs evolve or the device needs to be replaced.<sup>32</sup>

### ***Comparators***

The following therapy is currently being used to make decisions about managing individuals requiring a pacemaker: a conventional single-chamber pacemaker.

### ***Outcomes***

The general outcomes of interest are treatment-related mortality and morbidity. Specifically, the short-term outcomes include acute complication-free survival rate, the electrical performance of the device, including the pacing capture threshold, and adverse events, including procedural and postprocedural complications. Long-term outcomes include chronic complication-free survival rate, the electrical performance of the device, including pacing impedance and pacing thresholds, and chronic complications, including any system explant, replacement (with and without system explant), and repositions. Further, analysis of summary statistics regarding battery length is important.

To assess short-term safety, the first 30 days postimplant is generally considered appropriate because most device and procedural complications occur within this time frame. To assess long-term efficacy and safety as well as issues related to device end-of-life, a follow-up to 9 to 12 years postimplant with an adequate sample size are required to characterize device durability and complications with sufficient certainty.

### ***Study Selection Criteria***

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies on the currently marketed version of the technology were sought.
- Studies with duplicative or overlapping populations were excluded.

### ***Review of Evidence***

#### ***Systematic Reviews***

Wu et al (2023) conducted a systematic review and meta-analysis on the efficacy and safety of leadless pacemakers with atrioventricular synchronous pacing (Tables 2 to 4).<sup>33</sup> Eight prospective and retrospective single-arm observational studies were included in the meta-analyses. In 8 studies atrioventricular (AV) synchrony (AVS) proportion had a pooled mean of 78.9% (95% confidence interval [CI]: 71.9% to 86.0%, N=303). In 4 studies manually optimized reprogramming of AVS was studied. The mean difference between baseline and post-programming AVS was 11.3% (95% CI: 7.0% to 15.7%,  $p < .01$ , N=112). In 3 studies left ventricular outflow tract velocity time integral (LVOT-VTI) was compared with the algorithm programmed to VVI and VDD modes. The mean difference was 1.9 cm (95% CI: 1.2 to 2.6 cm,  $p < .01$ , N=137). Seven studies (N=351) reported safety endpoints with a total of 22 complications related to the AV algorithm or procedures reported (6.3%). The authors noted several

limitations of the meta-analysis: 1) there were no RCTs, 2) the approach to measuring AVS varied among the studies, 3) there was high heterogeneity for the pooled AVS proportion, 4) the studies represented data differently, so data needed to be estimated and transformed to combine, and 5) there were few studies with small cohorts included. The authors concluded the results demonstrated leadless pacemakers with AVS are effective and safe.

**Table 2. Trials Included in Systematic Review and Meta-analyses**

Trials	Systematic Reviews/Meta-Analyses
	Wu et al (2023) <sup>33</sup> .
Neugebauer et al (2022) <sup>34</sup> .	●
Mechulan et al (2022) <sup>35</sup> .	●
Kowlgi et al (2022) <sup>36</sup> .	●
Chinitz et al (2022) <sup>37</sup> ; AccelAV	●
Briongos-Figuero et al (2022) <sup>38</sup> .	●
Arps et al (2021) <sup>39</sup> .	●
Steinwender et al (2020) <sup>40</sup> ; MARVEL 2	●
Chinitz et al (2018) <sup>41</sup> ; MARVEL	●

AccelAV: Accelerometer Sensing for Micra AV; CED: coverage with evidence development; MARVEL: Micra Atrial tRacking using a Ventricular accELerometer.

**Table 3. Systematic Review and Meta-analyses Characteristics**

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Wu et al (2023) <sup>33</sup> .	To September 2022	8	Patients implanted with Micra AV Leadless Pacemaker	464 (20 to 152)	Prospective and retrospective observational studies	NR

NR, not reported.

**Table 4. Systematic Review and Meta-analyses Results**

Study	AVS proportion (%)	Optimized AVS proportion (%)	Change in LVOT-VTI between VVI and VDD pacing modes (cm)
Wu et al (2023) <sup>33</sup> .			
Total N	303	112	137
Pooled effect (95% CI)	MRAW, 78.93 (71.87 to 85.98)	MD, 11.33 (6.96 to 15.71)	MD, 1.93 (1.24 to 2.61)
P (p)	90% (<.01)	13% (.33)	0% (.85)

AVS: atrioventricular synchrony; CI: confidence interval; LVOT-VTI: left ventricular outflow tract velocity time integral; MD: mean difference; MRAW: raw mean.

## Randomized Controlled Trials

### Micra Leadless Pacemaker

Garweg et al (2023) conducted a prospective, un-blinded, randomized, noninferiority, single center study (N=51) comparing outcomes in individuals implanted with a single-chamber Micra leadless pacemaker (n=27) or a conventional single-chamber ventricular pacemaker (n=24).<sup>42</sup> The primary endpoints were related to mechanical outcomes, including change in left ventricular ejection fraction (LVEF) and global longitudinal strain (GLS) during a 12-month follow up period. At 12 months, both groups showed similar worsening in left ventricular function. The change in LVEF was  $-10 \pm 7.3\%$  in the Micra group and  $-13.4 \pm 9.9\%$  in the conventional group ( $p=.218$ ). The change in GLS was  $5.7 \pm 6.4$  in the Micra group and  $5.2 \pm 3.2$  in the conventional group ( $p=.778$ ). For the secondary endpoints, the Micra group had no significant change in tricuspid ( $p=.195$ ) and mitral ( $p=.460$ ) valve function and the conventional group had significant worsening in tricuspid ( $p=.001$ ) and mitral ( $p=.017$ ) valve function over 12 months. Change in valve function over 12 months between the groups was significantly different for the tricuspid valve ( $p=.009$ ) and not significantly different for the mitral valve ( $p=.304$ ). Median N-terminal-pro hormone B-type natriuretic peptide levels at 12 months was lower in the

Micra group (970 pg/dL) compared to the conventional group (1394 pg/dL) ( $p=.041$ ). For electrical performance, over 12 months the Micra group had higher impedance ( $p<.001$ ) and lower pacing threshold ( $p<.001$ ) compared to the conventional group, however there was no interaction between time and intervention. All implant procedures for both groups were successful, with no acute major complications. The authors conclude that Micra is non inferior to conventional pacemakers, with comparable impacts on ventricular function and less valvular dysfunction. Study characteristics and key results are summarized in Tables 5 and 6.

**Table 5. Summary of Key RCT Characteristics**

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Micra Leadless Pacemaker	Conventional Single-Chamber Ventricular Pacemaker
Garweg et al (2023) <sup>42</sup>	NR	1	2018-2020	Patients $\geq 18$ years old with a Class I or II indication for a single-chamber ventricular pacemaker	n=27	n=24

NR: not reported; RCT: randomized controlled trial.

**Table 6. Summary of Key RCT Results**

Study	LVEF (%)	GLS (%)
Garweg et al (2023) <sup>42</sup>	Change from baseline at 12 months	Change from baseline at 12 months
N	51	51
Micra Leadless Pacemaker (n=27)	-10.3 $\pm$ 7.3	5.7 $\pm$ 6.4
Conventional Single-Chamber Ventricular Pacemaker (n=24)	-13.4 $\pm$ 9.9	5.2 $\pm$ 3.2
p-value	.218	.778

GLS: global longitudinal strain; LVEF: left ventricular ejection fraction; RCT: randomized controlled trial.

## Nonrandomized Controlled Trials

### Micra Leadless Pacemaker

#### Pivotal Trial

The pivotal investigational device exemption (IDE) trial was a prospective single cohort study enrolling 744 patients with a class I or II indication for implantation of a single-chamber ventricular pacemaker based on national guidelines. Details on the design<sup>43</sup>, and results of the IDE trial have been published.<sup>44,45,46</sup> Trial characteristics and results at 6 months are summarized in Tables 7 and 8, respectively. System performance from the pivotal trial has been published,<sup>47</sup> but results are not discussed further.

Of the 744 patients enrolled, implantation of the Micra transcatheter pacing system was successful in 719 (99.2%) of the 725 patients who underwent the procedure. The demographics of the trial population were typical for a single-chamber pacemaker study performed in the U.S., with 42% being female and an average age of 76 years. Sixty-four percent had a pacing indication associated with persistent or permanent atrial arrhythmias, 72.6% had any atrial fibrillation at baseline, and 27.4% did not have a history of atrial fibrillation. Among those 27.4% (n=199) without atrial fibrillation, 16.1% (n=32) had a primary indication of sinus bradycardia and 3.5% (n=7) had a primary indication of tachycardia-bradycardia.<sup>46</sup>

The IDE trial had 2 primary endpoints related to safety and efficacy. The trial would meet its safety endpoint if the lower bound of the 95% CI for the rate of freedom from major complications related

to the Micra transcatheter pacing system or implantation procedure exceeded 83% at 6 months. Major complications were defined as those resulting in any of the following: death, permanent loss of device function due to mechanical or electrical dysfunction of the device (e.g., pacing function disabled, leaving device abandoned electrically), hospitalization, prolonged hospitalization by at least 48 hours, or system revision (reposition, replacement, explant).<sup>28</sup> The trial would meet its efficacy endpoint if the lower bound of the 95% CI for the proportion of patients with adequate pacing capture thresholds (PCT) exceeded 80% at 6 months. PCT as an effectiveness objective is a common electrical measure of pacing efficacy and is consistent with recent studies. Pacing capture threshold measured in volts is defined as the minimum amount of energy needed to capture the myocardial tissue electrically. Unnecessary high pacing output adversely shortens the battery life of the pacemaker and is influenced by physiologic and pharmacologic factors.<sup>28</sup> As per the FDA, demonstrating that "PCT is less than 2 Volts for the vast majority of subjects will imply that the Micra system will have longevity similar to current pacing systems since Micra's capture management feature will nominally set the safety margin to 0.5 Volts above the PCT with hourly confirmation of the PCT."<sup>28</sup>

Safety and efficacy results of the IDE trial are summarized in Table 8. At 6 months, the trial met both of its efficacy and safety primary endpoints including freedom from major complications related to the system or procedure in 96.0% of the patients (95% CI, 93.9% to 97.3%), compared with a performance goal of 83%, and an adequate pacing capture threshold in 98.3% of the patients (95% CI, 96.1% to 99.5%), compared with a performance goal of 80%.<sup>46</sup>

Quality of life results of the IDE trial were published in 2018. At baseline and 12 months, 702 (98%) and 635 (88%) participants completed the 36-Item Short Form questionnaire, respectively.<sup>45</sup> The mean 36-Item Short Form Physical Component Scale at baseline was 36.3 (standard deviation [SD], 9.0) and the mean 36-Item Short Form Mental Component Scale was 47.3 (SD, 12.5); the general population mean for both scores is 50. Both the Physical Component Scale and Mental Component Scale improved at 12 months post-implant to a mean Physical Component Scale score of 38.6 (SD, 9.4;  $p < .001$ ) and a mean Mental Component Scale score of 50.7 (SD, 12.2;  $p < .001$ ) compared with baseline.

IDE trial results were compared post hoc with a historical cohort of 2667 patients generated from 6 previous pacemaker studies, conducted between 2005 and 2012 by Medtronic, that evaluated the performance requirement at 6 months postimplant of right ventricle pacing leads (single-chamber rates obtained by excluding any adverse events only related to the right atrial lead from the analysis). The Micra device was associated with fewer complications than the historical control (4.0% vs. 7.4%; hazard ratio [HR], 0.49; 95% CI, 0.33 to 0.75;  $p = .001$ ).<sup>46</sup> Because there were differences in baseline patient characteristics between the 2 cohorts (patients in the historical cohort were younger and had a lower prevalence of coexisting conditions vs. the IDE trial), an additional propensity-matched analysis was conducted. It showed similar results (HR, 0.46; 95% CI, 0.28 to 0.74). As per the FDA, the lower rate of major complications with the Micra device was driven by reductions in access site events (primarily implant site hematoma and implant site infections), pacing issues (primarily device capture and device pacing issues), and fixation events (there was no device or lead dislodgements in the Micra IDE trial).<sup>11</sup>

While the overall rate of complications was low, the rate of major complications related to cardiac injury (i.e., pericardial effusion or perforation) was higher in the Micra IDE trial than in the 6 reference Medtronic pacemaker studies (1.6% vs. 1.1%;  $p = .288$ ).<sup>11</sup> Thus, there appears to be a trade-off between types of adverse events with the Micra transcatheter pacing system and conventional pacemakers. While adverse events related to leads and pocket are eliminated or minimized with the Micra device, certain adverse events (e.g., groin vascular complications, vascular or cardiac bleeding) occur at a higher frequency or are additive (new events) compared with conventional pacemakers. Of these, procedural complications (e.g., acute cardiac perforations) that were severe enough to result in tamponade and emergency surgery were most concerning.<sup>11</sup>

In addition to lack of adequate data on long-term safety, effectiveness, reliability, and incidence of late device failures and battery longevity, there is also inadequate clinical experience with issues related to devices that have reached end-of-life, including whether to extract or leave the device in situ and possible device-device interactions.<sup>48</sup> There are limited data on device-device interactions (both electrical and mechanical) that may occur when there is a deactivated Micra device alongside another leadless pacemaker or when a leadless pacemaker and transvenous device are both present. Even though there have been few device retrievals and very limited experience with the time course of encapsulation of these devices in humans, it is highly likely that these devices will be fully encapsulated by the end of its typical battery life, and therefore device retrieval is unlikely.<sup>48</sup> Current recommendations for end-of-device-life care for a Micra device may include the addition of a replacement device with or without explantation of the Micra device, which should be turned off.<sup>49</sup> Grubman et al (2017) reported on system revisions including patients from the IDE study (n=720) and the Micra Transcatheter Pacing System Continued Access Study (n= 269; NCT02488681).<sup>50</sup> The Continued Access study was conducted to allow for continued access of the Micra in the same centers as the IDE study while the device was pending the FDA approval. The mean follow-up duration was 13 months (16 months in the IDE patients and 2 months in the continued access patients). There were 11 system revisions in 10 patients, corresponding to a 1.4% (95% CI, 0.7% to 2.6%) act times rate of revisions through 24 months. Micra was disabled and left in situ in 7 of 11 revisions including 5 patients in which there was no retrieval attempt, 1 patient in which retrieval was aborted because of fluoroscopy failure, and 1 patient in which retrieval was unsuccessful because of inability to dislodge the device. There were 3 percutaneous retrievals and 1 retrieval during surgical valve replacement. There were no complications associated with retrievals. The report indicates that when a transvenous system was implanted with a deactivated Micra, there were no reported interactions between the 2 systems, although it is not clear how often this occurred. In the historical controls from the IDE study, there were 123 revisions in 117 patients through 24 months (act times rate, 5.3%; 95% CI, 4.4 to 6.4). Using propensity score matching, the reduction in system revisions for Micra compared to historical controls was significant (HR, 0.27; 95% CI, 0.14 to 0.54; p<.001).

### **Micra Postapproval Experience**

The FDA approval of the Micra transcatheter pacing system was contingent on multiple postapproval studies to provide reasonable assurance of continued safety and effectiveness of the device. Among these, the Micra Transcatheter Pacing System Post-Approval Study, a global, prospective, observational, multicenter study, enrolled 1830 patients to collect data on 1741 patients to estimate the acute complication rate within 30 days of the implant, 500 patients to estimate the 9-year complication-free survival rate, and a minimum of 200 patients with a Micra device revision for characterizing device end of service.<sup>28</sup> As per the protocol, if a subsequent device is placed and the Micra is deactivated or explanted, Medtronic would contact the implanting center and request the patient's clinical data concerning the revision. All such data would be summarized, including the type of system revision, how the extraction was attempted, success rate, and any associated complications.<sup>48</sup>

Study characteristics and results at 1 year (reported in the FDA documents and published) are summarized in Table 7 and 8, respectively. The postapproval study completed enrollment in early March 2018. The definition of a major complication in the postapproval study was the same as the Micra IDE trial. Although some patients who participated in the IDE study consented to also participate in the post-approval registry (PAR) study, the publication excludes those patients from analysis and therefore includes an independent population. Results summarized in Table 8 summarize the data at 30 days published by Roberts et al (2017)<sup>51</sup>, and El-Chami et al (2018)<sup>52,53</sup> with a mean follow-up of 6.8 months for 1817 patients, of whom 465 patients had a follow-up for more than 1 year.

At 30 days, the major complication rate was 1.51% (95% CI, 0.78 to 2.62). The major complication rate was lower in the postapproval study than in the IDE trial (odds ratio, 0.58; 95% CI, 0.27 to 1.25) although this did not reach statistical difference. The lower rate of major complications was

associated with a decrease in events that led to hospitalization, prolonged hospitalization, or loss of device function in the postapproval study compared with the IDE trial.<sup>51</sup> A subsequent subgroup analysis of patients who did not receive perioperative anticoagulation treatment, who received interrupted anticoagulation treatment, or who received continuous anticoagulation treatment did not find a significant difference in rates of acute major complications according to anticoagulation strategy (3.1%, 2.6%, and 1.5%, respectively;  $p=.29$ ). The most common major complication was pacing problems, including elevated threshold and device capturing issues.<sup>54</sup> A subgroup analysis of patients treated with and without atrioventricular node ablation (AVNA) at the time of Micra implantation identified a significantly higher risk of major complications at both 30 days (7.3% vs. 2.0%;  $p<.001$ ) and 36 months (HR, 3.81; 95% CI, 2.33 to 6.23;  $p<.001$ ) in the AVNA group versus those without AVNA.<sup>55</sup>

After a mean follow-up of 6.8 months, the estimated major complication rate at 12 months was 2.7% (95% CI, 2.0% to 3.7%), corresponding to 46 major complications in 41 patients, the majority of which (89%) occurred within 30 days of implantation. The major complications included 14 device pacing issue events, 11 events at the groin puncture site, 8 cardiac effusion/perforation events, 3 infections, 1 cardiac failure event, 1 cardiomyopathy event, and 1 pacemaker syndrome event. Authors compared these results with the same historical cohort of 2667 patients used in the IDE trial and reported a 63% reduction in the risk for major complications through 12 months with the Micra transcatheter pacing system relative to conventional pacemakers (HR, 0.37; 95% CI, 0.27 to 0.52). Additionally, the risk for major complications was lower in the Micra postapproval study than in the IDE trial, but it was a statistically significant difference (HR, 0.71, 95% CI, 0.44 to 1.1).<sup>52</sup> The reduction in major complications compared to historical controls was primarily driven by a significant 74% (95% CI, 54% to 85%;  $p=.0001$ ) relative risk reduction in system revisions and 71% (95% CI, 51% to 83%;  $p=.0001$ ) relative risk reduction in hospitalizations. The reduction in risk compared to the IDE trial was driven by significantly lower pericardial effusion rates in the post-approval study.

El-Chami et al (2024) reported results on a 5-year follow-up of the Micra PAR study.<sup>56</sup> Major complication rates for individuals with an attempted Micra VR implant procedure ( $n=1809$ ) was 4.47% (95% CI, 3.6% to 5.5%) at 60 months and there were no Micra removals due to infection reported during follow-up. The authors concluded that low rates of major complications, low incidence of infection, and low rates of system revisions have been reported in long-term follow-up. Study characteristics and results are summarized in Tables 7 and 8.

Roberts et al (2023) conducted a prospective, single-arm study of the Micra Acute Performance European and Middle Eastern (MAP EMEA) registry and compared results to the IDE and PAR studies.<sup>57</sup> The primary endpoint was 30-day major complication rate. For the MAP EMEA individuals ( $N=928$ ) at 30 days there were 24 major complications in 24 individuals (2.59%; 95% CI, 1.66% to 3.82%). Of these events, 10 were at the groin and puncture site, 6 cardiac effusion/perforation events, 4 device pacing issues, 3 infection events (2 resulting in system revisions), and 1 event of hemodynamic instability. Through study follow-up after 30 days (mean duration,  $9.7 \pm 6.5$  months), there were 11 more major complications in 9 individuals adjudicated as related to the Micra VR device or procedure. The MAP EMEA cohort, compared to the IDE ( $N=726$ ) and PAR ( $N=1811$ ) study cohorts, had less heart failure (8.3% vs. 18.0% vs. 13.0%,  $p<.001$ ) and coronary artery disease (19.9% vs. 28.2% vs. 22.0%,  $p<.001$ ) and were more likely to have renal dysfunction (28.9% vs. 20.5% vs. 21.5%,  $p<.001$ ) and be on dialysis (10.2% vs. 3.9% vs. 7.9%,  $p<.001$ ). However, a limitation of this comparison is the median duration of follow-up varied among the MAP EMEA, IDE, and PAR study cohorts (9.6, 19.6, and 34.2 months, respectively). Study characteristics and results are summarized in Tables 7 and 8. Piccini et al (2021) published initial data from the ongoing Longitudinal Coverage with Evidence Development Study on Micra Leadless Pacemakers (Micra CED).<sup>58</sup> Patients implanted between March 2017 and December 2018 were identified and included from a fee-for-service population with at least 12 continuous months of Medicare enrollment prior to device implantation. A total of 5746 patients with single-chamber leadless Micra pacemakers and 9662 patients with transvenous pacemakers were analyzed. Patients with a Micra pacemaker were more likely to have end-stage

kidney disease ( $p < .001$ ) and a higher mean Charlson Comorbidity Index score (5.1 vs. 4.6;  $p < .001$ ). The unadjusted acute 30-day complication rate was higher in the Micra subgroup (8.4% vs. 7.3%;  $p = .02$ ), but no significant difference was found following adjustment for patient characteristics ( $p = .49$ ). Pericardial effusion and/or perforation within 30 days of implantation was significantly higher in the Micra population in the adjusted model (0.8% vs. 0.4%;  $p = .004$ ). Patients with Micra pacemakers had a 23% lower risk of complications at 6 months compared to patients receiving a transvenous pacemaker (HR, 0.77; 95% CI, 0.62 to 0.96;  $p = .02$ ) and a 37% reduction in rates of device revision after adjustment for patient baseline characteristics. The 30-day all-cause mortality rate was not significantly different between groups in both unadjusted ( $p = .14$ ) and adjusted analyses ( $p = .61$ ). The study is ongoing with an estimated study completion data of June 2025 (see Table 19). Study characteristics and results are summarized in Tables 7 and 8.

El-Chami et al (2022) subsequently compared reinterventions, chronic complications, and all-cause mortality at 2 years in patients implanted with the Micra leadless pacemaker or a transvenous pacemaker in the Micra Coverage with Evidence Development study.<sup>59</sup> Patients implanted with leadless ( $n = 6219$ ) or transvenous pacemakers ( $n = 10,212$ ) were identified from Medicare claims data and compared contemporaneously. Patients receiving leadless pacemakers had higher rates of end-stage renal disease (12.0% vs. 2.3%) and a higher Charlson comorbidity index (5.1 vs. 4.6). Patients with leadless pacemakers received 37% fewer reinterventions (adjusted HR, 0.62; 95% CI, 0.45 to 0.85;  $p = .003$ ), defined as system revision lead revision or replacement, system replacement, system removal, or system switch or upgrade to an alternative device. Patients implanted with leadless pacemakers also experienced fewer chronic complications (2.4% vs. 4.8%; adjusted HR, 0.69; 95% CI, 0.60 to 0.81;  $p < .0001$ ). However, patients receiving leadless pacemakers experienced significantly more other complications, driven by higher rates of pericarditis (adjusted, 1.6% vs. 0.8%;  $p < .0001$ ). Adjusted all-cause mortality at 2 years was not significantly different between groups (adjusted HR, 0.97; 95% CI, 0.91 to 1.04;  $p = .37$ ) despite the higher comorbidity index in patients implanted with a Micra device. Study interpretation is limited by reliance on claims data. It is unclear whether all patients receiving leadless devices were considered medically eligible for transvenous devices. Study characteristics and results are summarized in Tables 7 and 8.

Boveda et al (2023) reported 2-year outcomes from the Micra CED study in a subgroup of individuals at higher risk of pacemaker complications.<sup>60</sup> Participants were considered high-risk if they had a diagnosis of chronic kidney disease Stages 4 to 5, end-stage renal disease, malignancy, diabetes, tricuspid valve disease (TVD), or chronic obstructive pulmonary disease (COPD) 12 months prior to implant. They compared outcomes between high-risk individuals with leadless-VVI pacemakers ( $n = 9858$ ) and transvenous-VVI pacemakers ( $n = 12157$ ). The leadless-VVI group had fewer complications compared to the transvenous-VVI group in those with malignancy (HR, 0.68; adjusted CI, 0.48 to 0.95), diabetes (HR, 0.69; adjusted CI, 0.53 to 0.89), TVD (HR, 0.60; adjusted CI, 0.44 to 0.82), and COPD (HR, 0.73; adjusted CI, 0.55 to 0.98), had fewer reinterventions in those with diabetes (HR, 0.58; adjusted CI, 0.37 to 0.89), TVD (HR, 0.46; adjusted CI, 0.28 to 0.76), and COPD (HR, 0.51; adjusted CI, 0.29 to 0.90), and lower rates of combined outcome of device complications and select reinterventions in those with malignancy (HR, 0.52; adjusted CI, 0.32 to 0.83), diabetes (HR, 0.52; adjusted CI, 0.35 to 0.77), TVD (HR, 0.44; adjusted CI, 0.28 to 0.70), and COPD (HR, 0.55; adjusted CI, 0.34 to 0.89). The authors conclude that in this real-world study, individuals with leadless pacemakers had lower 2-year complications and reinterventions rates than individuals with transvenous pacemakers in several high-risk subgroups.

Three-year outcomes from the Micra Coverage with Evidence Development study were published by Crossley et al in 2023.<sup>61</sup> Patients implanted with leadless pacemakers had a 32% lower rate of chronic complications (HR, 0.68; 95% CI, 0.59 to 0.78;  $p < .001$ ) and a 41% lower rate of any reinterventions compared to patients receiving a transvenous pacemaker (HR, 0.59; 95% CI, 0.44 to 0.78;  $p = .0002$ ). Use of a leadless system was also associated with a 49% lower rate ( $p = .01$ ) of upgrades to a dual-chamber system and a 35% lower rate ( $p = .002$ ) of upgrades to cardiac resynchronization therapy. Heart failure hospitalizations at 3 years were slightly, but significantly lower in adjusted time-to-

event models (HR, 0.90; 95% CI, 0.83 to 0.97;  $p=.005$ ) in patients receiving a leadless system. All-cause mortality rates at 3 years between leadless and transvenous systems were not significantly different after accounting for differences in baseline characteristics (HR, 0.97; 95% CI, 0.92 to 1.03;  $p=.32$ ). No significant differences in the composite endpoint of time to heart failure hospitalization or death were observed for the original full cohort ( $p=.28$ ) or in a subgroup of patients without a history of heart failure ( $p=.98$ ). Study characteristics and results are summarized in Tables 7 and 8.

Crossley et al (2024) reported outcomes from the Micra AV Coverage with Evidence Development study comparing individuals implanted with Micra AV ( $n=7471$ ) to a comparator cohort ( $n=107,800$ ) of individuals implanted with a dual-chamber transvenous pacemaker regardless of pacing indication.<sup>62</sup> At 30 days, the adjusted overall complications were 8.6% for Micra AV group and 11.0% for dual chamber transvenous group ( $p<.0001$ ) and the adjusted all-cause mortality was 6.0% for the Micra AV group and 3.5% for the dual chamber transvenous group ( $p<.0001$ ). At 6 months, the Micra AV group had significantly lower rates of complications (adjusted HR, 0.50; 95% CI, 0.43 to 0.57;  $p<.0001$ ), lower reinterventions (adjusted HR, 0.46; 95% CI, 0.36 to 0.58;  $p<.0001$ ), and higher all-cause mortality (adjusted HR, 1.69; 95% CI, 1.57 to 1.83;  $p<.0001$ ) compared to the dual chamber transvenous group. The authors concluded that leadless pacemakers with AV synchronous pacing demonstrated safety and efficacy. The authors noted limitations to the study. First, Medicare claims data was used, which is a secondary database without traditional clinical adjudication. Second, the comparator cohort included all individuals regardless of pacing indications, because it could not be reliably determined from the data. Study characteristics and results are summarized in Tables 7 and 8.

Hauser et al (2021) analyzed the Food and Drug Administration's Manufacturers and User Facility Device Experience (MAUDE) database to capture major adverse clinical events (MACE) associated with the Micra device compared to the Medtronic CapSureFix transvenous pacing system.<sup>63</sup> In a search of reports from 2016 through 2020, 363 MACE and 960 MACE were identified for the Micra and CapSureFix devices, respectively. For the Micra device, significantly higher rates of death (26.4% vs. 2.4%;  $p<.001$ ), cardiac tamponade (79.1% vs. 23.4%;  $p<.001$ ), and rescue thoracotomy (27.3% vs. 5.2%;  $p<.001$ ) were reported. Micra patients were more likely to require cardiopulmonary resuscitation (21.8% vs. 1.1%) and to suffer hypotension or shock (22.0% vs. 5.8%) compared to CapSureFix recipients ( $p<.001$ ). While the overall incidence of myocardial and vascular perforations and tears that may result in cardiac tamponade and death in Micra recipients is estimated to be low ( $<1\%$ ), the authors note that Micra patients were more likely to survive these events if they received surgical repair ( $p=.014$ ). A subsequent analysis of the MAUDE database focused on rates of Micra perforations from 2016 to 2021. Hauser et al (2022) identified 563 perforations reported within 30 days of implant, resulting in 150 deaths (27%), 499 cardiac tamponades (89%), and 64 pericardial effusions (11%).<sup>64</sup> Emergency surgery was required in 146 patients (26%). Half of all perforations were associated with 139 device problems (25%), 78 operator use problems (14%), and 62 combined device and operator use problems (11%). The most common device problem leading to redeployment were non-capture or inadequate electrical values that required implantable pulse generator recapture and reimplantation or replacement. No device or operator use problems were identified for the remaining 282 perforations (50%), but these were associated with 78 deaths, 245 tamponades, and 57 emergency surgeries. The authors concluded that Micra implantation should be confined to specialized centers capable of managing emergency complications and that a risk score for perforation should be developed and validated. Importantly, these analyses are limited by the passive nature of the FDA's post-market device surveillance system, which may not capture all voluntary reports from healthcare professionals, consumers, and patients. Such analyses carry a high risk of ascertainment bias which may lead to overestimation of the true prevalence of adverse events.

Maclean et al (2023) conducted a retrospective study of data from the MAUDE database for events related to Micra tine fracture and damage.<sup>65</sup> Of the 4241 medical device reports, these included 2104 Micra VR and 2167 Micra AV reports. After duplicates were excluded, there were 230 reports including

terms "fracture" and "tine." There were 7 reports of tine fractures and 19 reports of tine damage. Clinical signs and symptoms were reported in 2 of the 7 (29%) tine fracture cases and 4 of 19 (21%) of the tine damage cases. The authors concluded there is a low frequency of tine fracture and tine damage reports with the tine-based fixation mechanism of the Micra leadless pacing system. Multiple studies have analyzed data from the International Leadless Pacemaker Registry (i-LEAPER), a European, multicenter, open-label, independent, and physician-initiated observational registry of the Micra leadless pacemaker devices. Mitacchione et al (2023) used i-LEAPER data to investigate outcomes of leadless pacemaker implantation following transvenous lead extraction at a median follow-up of 33 months.<sup>66</sup> The study cohort (N=1179) was grouped by those with leadless pacemaker implantation after transvenous lead extraction (TLE) (n=184) or de novo (n=995). There was no difference in leadless pacemaker-related major complications between TLE (1.6%) and de novo (2.2%) (p=.785) or all-cause mortality between TLE (5.4%) and de novo (7.8%) (p=.288). Pacing threshold was higher in the TLE group compared to the de novo group at implantation and follow-up. The authors noted that when the leadless pacemaker was deployed at a different right ventricular location than where the previous transvenous right ventricular lead was extracted, there was a lower proportion of individuals with high pacing threshold at implantation through 12-months follow-up. In another study by Mitacchione et al (2023) using the i-LEAPER database, they assessed sex differences in leadless pacemaker implantation.<sup>67</sup> The authors noted that of the overall population (N=1179), 64.3% were male. At median follow-up (25 months), female sex was not associated with leadless pacemaker-related major complications (HR, 2.03; 95% CI, 0.70 to 5.84; p=.190) or all-cause mortality (HR, 0.98; 95% CI, 0.40 to 2.42; p=.960). The authors conclude that females underrepresented in the study, but had comparable safety and efficacy outcomes to males.

Lenormand et al (2023) conducted a retrospective observational study on the efficacy and safety of leadless cardiac pacing.<sup>68</sup> Individuals (N=400) implanted with Micra VR (n=328) and Micra AV (n=72) were included in the analysis. The pacing threshold was similar between groups and remained stable through follow-up. There was no difference between median chronic pacing threshold between Micra VR (0.5 V) and Micra AV (0.5 V) (p=.87). In the overall population there were 14 individuals (3.5%) with major perioperative complications, 93% of which were in the Micra VR group. There were 116 deaths (29%) during follow-up, with mortality rates of 18% and 55% at 1 and 5 years, respectively. Pacemaker syndrome occurred in 6 (1.8%) individuals in the Micra VR group and no cases in the Micra AV group (p=.60). Pacing-induced cardiomyopathy occurred in 4 (1.2%) individuals in the Micra VR group and 2 (2.8%) individuals in the Micra AV group (p=.30). Overall, the authors conclude leadless pacing is safe. However, this study is limited as a retrospective observational study and it did not have a comparison conventional transvenous cardiac pacing group.

Strik et al (2023) evaluated the safety and efficacy of Micra VR in young adults between 18 and 40 years (N=35) in a multicenter, retrospective, observational study.<sup>69</sup> The primary safety endpoint was freedom from system-related or procedure-related major complications at 6 months. All patients met the primary safety endpoint at 6 months. During follow-up (26 ± 15 months), there were 3 deaths. The authors note these were not related to device implantation or malfunction. The authors conclude the results demonstrated favorable safety for the Micra VR. However, this study is limited by its small sample size and retrospective design.

Shah et al (2023) conducted a retrospective study reporting results from the Pediatric and Congenital Electrophysiology Society (PACES) Transcatheter Leadless Pacemakers (TLP) registry.<sup>70</sup> Individuals (N=63) were ≤21 years of age and met a class I or II indication for pacemaker implantation for a Micra device. Implantation was successful in 62 (98%) of the participants. During the follow-up period (mean, 9.5 ± 5.3 months), there were 10 (16%) complications including 1 cardiac perforation/pericardial effusion, 1 nonocclusive femoral venous thrombus, and 1 retrieval and replacement of TLP due to high thresholds. There were no deaths or device-related infections reported during the study period.

Ando et al (2023) studied the safety and performance of the Micra VR in the Micra Acute Performance (MAP) Japan cohort (N=300).<sup>71</sup> Within 30 days of implantation, there were 11 major complications in 10 individuals (3.33%; 95% CI, 1.61 to 6.04). These included 3 cardiac effusions/perforations, 2 events at the groin puncture site, 2 cases of deep vein thrombosis, and 4 pacing issues leading to system modifications. There were 2 deaths within 30 days of implantation, and a total of 22 deaths during the 12-month study period. The author conclude the safety and performance observed in this cohort was comparable to other global Micra trials. Study characteristics and results are summarized in Tables 7 and 8.

Racine et al (2023) conducted a single center, retrospective study of individuals implanted with a Micra only (n=72) or a Micra and concomitant or delayed AVNA (n=12).<sup>72</sup> Two patients in the Micra with AVNA group had acute pacing threshold, requiring device retrieval. This was a single center study with a small sample size, so further evidence is needed to investigate the safety of implantation of Micra with AVNA.

Two retrospective studies have investigated implantation of Micra devices after cardiac surgery and valve interventions. Kassab et al (2024) studied individuals (N=9) who underwent Micra AV implantation within 30 days post-transcatheter aortic valve replacement.<sup>73</sup> There were no procedural complications and at follow-up (mean, 353 days) capture threshold and lead impedance remained stable. Huang et al (2023) studied individuals (N=78) who received Micra VR (n=40) or Micra AV (n=38) implants who had undergone cardiac surgery (n=50) or transcatheter structural valve interventions (n=28).<sup>74</sup> During 1-year followup, there was 1 (1.3%) femoral access site hematoma requiring evacuation. Within 30 days, 4 (5.1%) patients were rehospitalized and 3 (3.8%) patients died. More evidence is needed to determine the safety of leadless pacemaker implantation after cardiac surgery and valve interventions. The authors of both papers noted several clinical characteristics and age contributed to the decision to implant leadless pacemakers instead of transvenous pacemakers. However, it is unclear whether these individuals were considered medically eligible for a conventional transvenous pacemaker.

### Atrioventricular Synchrony

Chinitz et al (2022) conducted a prospective, single-arm study (AccelAV) at 20 sites in the United States and Hong Kong to assess the efficacy of the Micra AV leadless pacemaker in promoting AVS in adults with a history of AV block (N=157).<sup>37</sup> This device uses an accelerometer and detection algorithm to mechanically sense atrial contractions to facilitate VDD pacing and AVS in individuals with normal sinus function. Based on a preliminary feasibility study (MARVEL 2),<sup>40</sup> a sample size of 150 individuals was expected to provide at least 50 individuals with complete AV block and normal sinus function to permit estimation of AVS. Micra AV implantation and completion of the 1-month study visit was achieved by 139 individuals, of which 54 (mean age, 77 years; 55.6% female) comprised the intended use population with a predominant heart rhythm of complete AV block with normal sinus rhythm. The primary endpoint was the rate of AVS during a 20-minute resting period at 1-month postimplant in these patients. Atrioventricular synchronous pacing was defined as a ventricular marker preceding a P wave within 300 ms, regardless of the underlying cardiac rhythm. Secondary endpoints included stability of AVS during rest between 1 and 3 months, percent AVS during a 24-hr ambulatory period at 1 month and change in stroke volume. Quality of life was also measured with the EQ-5D-3L health status assessment. At 1 month, AVS percentage at rest was 85.4% (95% CI, 81.1% to 88.9%; median, 90.0%) during VDD pacing, with 85.2% of patients achieving >70% resting AVS. At the 3-month visit, 37/54 remained in the same rhythm. Among these subjects, no significant change in AVS was detected (p=.43) between the 3-month (mean, 84.1%; 95% CI, 78.3% to 88.6%) and 1-month visits (mean, 84.1%; 95% CI, 81.2% to 89.9%). At the 1-month visit, average 24-hour ambulatory AVS was 74.5% (95% CI, 70.4% to 78.2%). EQ-5D-3L health status scores significantly improved by 0.07 points between baseline and 3 months (p=.031) among patients with complete AV block and normal sinus function. Ambulatory AVS percentage significantly increased from 71.9% to 82.6% (p<.001) in 20 patients who participated in a substudy at a mean follow-up of 9.5 months designed to characterize the impact of optimized device programming. Improvement in AVS

was most evident during elevated sinus rates between 80 and 110 bpm. In the safety cohort (n=152), there were 14 major complications, including 4 pericardial effusions and 2 heart failure events. One pericardial effusion resulted in perforation and death in a 92-year-old woman with high baseline risk. A second death was reported in an 83-year-old man at 127 days postimplant but was not considered system- or procedure-related. No device upgrades and 1 device explantation and replacement was reported during follow-up. Study interpretation is limited by lack of a comparator group and short duration of follow-up. The ongoing Micra AV Post-Approval Registry (NCT04253184) has follow-up planned through 3 years. The investigators also noted that the AVS percentage required to maintain a clinical benefit over time is unknown, but likely is not 100%.

Garweg et al (2023) conducted a real-world assessment of AV synchrony in leadless pacemakers.<sup>75</sup> They first conducted a retrospective analysis of participants from the MARVEL 2 study with persistent third degree AV block and normal sinus rhythm (n=40). The median atrial mechanical sensed-ventricular pacing (%AM-VP) was 79.1%, with a range of 21.6% to 95.0%, and was highly correlated with AVS measured from surface electrocardiogram ( $R^2 = 0.764$ ,  $p < .001$ ). The authors also conducted a large real-world analysis of individuals with Micra AV implants enrolled in the CareLink database with devices programmed to VDD mode (n=4384). They found that ventricular pacing exceeded 90% in 37.9% (n=1662) of these participants and was near 100% in 15.7% (n=689) of these participants. Overall, the authors concluded the results demonstrated stable AVS over time. Lenormand et al (2023) conducted a retrospective study comparing the Micra VR and AV devices in individuals with sinus rhythm and complete atrioventricular block (N=93).<sup>76</sup> Between the VR (n=45) and AV (n=48) groups mean ventricular pacing burden was comparable (77% vs. 82%;  $p = .38$ ), and there were more cases of pacemaker syndrome in the VR compared to AV group (5 patients vs. 0 patients;  $p = .02$ ). Atrioventricular synchrony was assessed in the AV group. Median total AVS was 79% and there was poor A4 sensing in 7 (15%) of patients. The authors conclude that the Micra AV was able to provide AVS in most patients and was associated with no cases of pacemaker syndrome. However, this study is limited by its retrospective design and small sample size. More evidence is needed to compare the effectiveness and safety of the Micra VR and AV devices.

### **Aveir Leadless Pacemaker Pivotal Trial**

The pivotal IDE trial of the Aveir leadless pacemaker (LEADLESS II - Phase 2; NCT04559945) was a multicenter, prospective single cohort study enrolling 200 patients with a guidelines-based indication for single-chamber pacing.<sup>29</sup> Primary results from the IDE trial have been summarized in a published research correspondence<sup>27</sup> and FDA documents.<sup>29</sup> Trial characteristics and results through 6 and 12 months are summarized in Tables 7 and 8, respectively.

Implantation of the Aveir leadless pacing system was successful in 196/200 (98%) trial subjects (mean age, 75.6 years; 37.5% female). The primary indication for pacing was chronic atrial fibrillation with second- or third-degree AV block (52.5%). The trial had 2 primary endpoints related to safety and efficacy. The trial would meet its safety endpoint if the lower bound of the 97.5% CI for the complication-free rate exceeded 86% at 6 weeks. A complication was defined as a device-or-procedure-related serious adverse event, including those that prevented initial implantation. The trial would meet its efficacy endpoint if the lower bound of the 97.5% CI for the composite success rate exceeded 85% at 6 weeks. The confirmatory effectiveness endpoint was considered met if the pacing threshold voltage was  $\leq 2.0$  V at 0.4 ms and the sensed R-wave amplitude was either  $\geq 5.0$  mV at the 6-week visit or  $\geq$  the value at implant.

Safety and efficacy results of the Aveir IDE trial are summarized in Table 8. At 6 weeks, the trial met both of its confirmatory safety and efficacy endpoints, including freedom from device-or-procedure-related complications in 96% of patients (95% CI, 92.2% to 98.2%), compared with a performance goal of 86%, and a composite success rate of 95.9% of patients (95% CI, 92.1% to 98.2%), compared with a performance goal of 85%. The 6-month complication-free rate was 94.9% (95% CI, 90.0% to 97.4%). The most frequent complications included 3 cardiac tamponade events and 3 premature

deployment events. The rate of cardiac perforation/tamponade/pericardial effusion was 1.5%. No dislodgement events were reported in the Aveir cohort.

Confirmatory secondary endpoints included assessment of an appropriate and proportional rate-response during a Chronotropic Assessment Exercise Protocol (CAEP) exercise protocol and an estimated 2-year survival rate.<sup>28</sup> The CAEP assessment was initiated in 23 subjects, of which 17 were considered analyzable. The rate-response slope was 0.93 (95% CI, 0.78 to 1.08), which fell within the prespecified range of 65% to 135%. The estimated 2-year survival rate based on the Nanostim Phase 1 cohort (N=917) was 85.3% (95% CI, 82.7% to 87.4%), which exceeded the performance goal of 80%. Reddy et al (2023) reported 1-year outcomes from the LEADLESS II IDE trial.<sup>77</sup> Confirmatory safety and efficacy endpoints at 1 year were both met for European regulatory approval, including freedom from device-or-procedure-related complications in 93.2% of patients (95% CI, 88.7% to 95.9%), compared with a performance goal of 83%, and a composite success rate of 95.1% (95% CI, 91.2% to 97.6%), compared with a performance goal of 80%. Most complications (11 of 15) were reported within the first 3 days post-implantation, including 4 cardiac tamponade events, 3 premature deployments with or without device migration, 2 access site bleeding events, 1 pulmonary embolism, and 1 case of deep vein thrombosis. Four long-term complications were reported between 3.8 and 9.5 months post-implantation, including 2 cases of heart failure and 2 cases of pacemaker-induced cardiomyopathy. Based on the device-use conditions in this analysis cohort, the investigators estimate that mean device battery longevity is  $17.6 \pm 6.6$  years (95% CI, 16.6 to 18.6).

Santobuono et al (2023) presented a case report of a Micra AV with a sudden battery malfunction, which resulted in successful extraction and replacement with a new device in the right ventricle.<sup>78</sup> The authors noted, to their knowledge, this is the first case of a sudden battery failure not related to elevated pacing threshold.

The current evidence on the use of the Aveir device is limited by a lack of adequate data on quality of life, long-term safety, effectiveness, reliability, and incidence of late device failures and direct evidence on battery longevity. While the device is designed to be retrieved when therapy needs evolve or the device needs to be replaced, there is currently inadequate clinical experience with issues related to devices that have reached end-of-life. Survival data for the currently marketed version of the Aveir device has not been reported.

**Table 7. Summary of Key Nonrandomized Trial Characteristics**

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up, mo
<b>Micra</b>						
Reynolds et al (2016) <sup>46</sup> ; NCT02004873	Prospective single cohort	19 countries in North America, Europe, Asia, Australia, and Africa	2013-2015	Patients who met a class I or II guidelines-based indication for pacing and suitable candidates for single-chamber ventricular demand pacing	Micra pacemaker (n=744)	6
Roberts et al (2017) <sup>51</sup> ;	Prospective single cohort	23 countries in North America, Europe, Asia, Australia, and Africa	2016-2018	Any patient to be implanted with a Micra device	Micra pacemaker (n=795 <sup>a</sup> , 1830 <sup>b</sup> , and 1809 <sup>c</sup> )	1.8a 6.8b 60 <sup>c</sup>
El-Chami et al (2018) <sup>52,53</sup> ;	Approval Study)					
El-Chami et al (2024) <sup>56</sup> ; NCT02536118						
Piccinni et al (2021) <sup>58</sup> .	Prospective Medicare registry	United States	2017-2018	All Medicare patients implanted with a leadless single-	Micra pacemaker (n=5746);	6

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up, mo
				chamber pacemaker or transvenous single-chamber pacemaker with at least 12 months of continuous Medicare enrollment prior to implantation	Transvenous pacemaker (n=9662)	
El-Chami et al (2022) <sup>59</sup> ,	Prospective Medicare registry	United States	2017-2018	All Medicare patients implanted with a leadless single-chamber pacemaker or transvenous single-chamber pacemaker with at least 12 months of continuous Medicare enrollment prior to implantation	Micra pacemaker (n=6219); Transvenous pacemaker (n=10,212)	24
Crossley et al (2023) <sup>61</sup> ,	Prospective Medicare registry	United States	2017-2018	All Medicare patients implanted with a leadless single-chamber pacemaker or transvenous single-chamber pacemaker with at least 12 months of continuous Medicare enrollment prior to implantation	Micra pacemaker (n=6219); Transvenous pacemaker (n=10,212)	36
Chinitz et al (2022) <sup>37</sup> ,	Prospective single-cohort	United States and Hong Kong	2020-2021	Adults with a history of AV block or complete AV block and normal sinus rhythm implanted with the Micra AV leadless pacemaker	Micra AV pacemaker (N=157)  Micra AV pacemaker in adult with complete AV block and normal sinus rhythm (n=54)	3
Roberts et al (2023) <sup>57</sup> ,	Prospective single-arm	14 countries in Europe and the Middle East	2018-2020	Patients intended to be implanted with a market-approved Micra VR device (MC1VR01)	Micra VR pacemaker (N=928)	12
Ando et al (2023) <sup>71</sup> ,	Prospective single-cohort	Japan	2019-2022	Patients implanted with a Micra VR device	Micra VR (N=300)	6
Crossley et al (2024) <sup>62</sup> ,	Prospective Medicare registry	United States	2020-2021	Patients implanted with a Micra AV or dual chamber transvenous pacemaker	Micra AV (n=7471); Transvenous pacemaker (n=107,800)	6
Aveir FDA SSED (2022); PMA P150035 <sup>29</sup> ; Reddy et al (2021) <sup>27</sup> ,	Prospective single cohort	43 sites in the United States, Canada, and Europe	2020-2021	Patients with a guidelines-based indication for single-chamber pacing	Aveir pacemaker (n=200)	6
Reddy et al (2023) <sup>77</sup> ,	Prospective single cohort	43 sites in the United States,	2020-2021	Patients with a guidelines-based	Aveir pacemaker (n=210)	12

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up, mo
		Canada, and Europe		indication for single-chamber pacing		

AV: atrioventricular; FDA: U.S. Food and Drug Administration; NCT: national clinical trial; PMA: premarket approval; SSED: Summary of Safety and Effectiveness Data.

<sup>a</sup> 30-day results reported by Roberts et al (2017).<sup>51</sup>

<sup>b</sup> Results after a mean follow-up of 6.8 months reported by El-Chami et al (2018)<sup>52,53</sup>.

<sup>c</sup> Results from 5-year follow-up reported by El-Chami et al (2024)<sup>56</sup>.

**Table 8. Summary of Key Nonrandomized Trial Results**

Study	Freedom From System- or Procedure-Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
<b>Micra IDE Trial</b>				
	6 Months	6 Months	6 Months	6 Months
<b>Reynolds et al (2016)<sup>46</sup></b>				
N	719 <sup>a</sup> ; 300 <sup>b</sup>	719	725	725
Micra	96.0%	98.3% ( $\leq 2.0$ V)	<ul style="list-style-type: none"> <li>• Death: 1 (0.1)</li> <li>• Loss of device function: 1 (0.1)</li> <li>• Hospitalization: 13 (2.3)</li> <li>• Prolonged hospitalization (<math>\geq 48</math> h): 16 (2.6)</li> <li>• System revision: 3 (0.4)</li> </ul>	TMCs: 28 in 25 patients (3.5%) <ul style="list-style-type: none"> <li>• DVT: 1 (0.1)</li> <li>• Pulmonary TE: 1 (0.1)</li> <li>• Events at groin puncture site: 5 (0.7)</li> <li>• Cardiac perforation: 11 (1.6)</li> <li>• Pacing issues: 2 (0.3)</li> <li>• Others: 8 (1.7)</li> </ul>
95% CI	93.9% to 97.3%	95.4% to 99.6%	NA	NA
	12 Months	12 Months	12 Months	12 Months
<b>Duray et al (2017)<sup>79</sup></b>				
N	726	NA	726	726
Micra	96.0%	NR (93%)	<ul style="list-style-type: none"> <li>• Death: NR (0.1)</li> <li>• Loss of device function: NR (0.1)</li> <li>• Hospitalization: NR (2.3)</li> <li>• Prolonged hospitalization (<math>\geq 48</math> h): NR (2.2)</li> <li>• System revision: NR (0.7)</li> <li>• Loss of device function: NR (0.3)</li> </ul>	TMCs: 32 in 29 patients (4.0) <ul style="list-style-type: none"> <li>• DVT: 1 (0.1)</li> <li>• Pulmonary TE: 1 (0.1)</li> <li>• Events at groin puncture site: 5 (0.7)</li> <li>• Cardiac perforation: 11 (1.6)</li> <li>• Pacing issues: 2 (0.3)</li> <li>• Others: 11 (1.7)</li> </ul>
95% CI	94.2% to 97.2%	NA		
<b>Micra Post-Approval Study</b>				

Study	Freedom From System- or Procedure-Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
	30 Days	30 Days	30 Days	30 Days
<b>Roberts et al (2017)<sup>51</sup>,</b>				
N	795	NA	795	795
Micra	97.3% <sup>d</sup>	87.2% ( $\leq 1.0$ V) 97.0% ( $\leq 2.0$ V)	<ul style="list-style-type: none"> <li>Death: 1 (0.13%)</li> <li>Hospitalization: 4 (0.50)</li> <li>Prolonged hospitalization (<math>\geq 48</math> h): 9 (1.01)</li> <li>System revision<sup>f</sup>: 2 (0.25)</li> </ul>	TMCs: 13 in 12 patients (1.51% [95% CI, 0.78 to 2.62]) <ul style="list-style-type: none"> <li>DVT: 1 (0.13)</li> <li>Events at groin puncture site: 6 (0.75)</li> <li>Cardiac effusion/perforation: 1 (0.13)</li> <li>Device dislodgement: 1 (0.13)</li> <li>Pacing issues: 1 (0.13)</li> <li>Others: 3 (0.38)</li> </ul>
OR (95% CI)	0.58 (0.27 to 1.25) <sup>e</sup>	NA	NA	NA
	1 Year	1 Year	1 Year	1 Year
<b>El-Chami et al (2018)<sup>53</sup>,</b>				
N	1817	NA	NA	1817
Micra	97.3% <sup>d</sup>	NA	NA	TMCs: 46 in 41 patients (2.7% [95% CI, 2.0% to 3.6%]) <ul style="list-style-type: none"> <li>Pericardial effusions: 8 (0.44)</li> <li>Dislodgement: 1 (0.06)</li> <li>Procedure-related infections: 3 (0.17)</li> <li>Procedure-related deaths: 5 (0.28)</li> </ul> As per FDA: Complications <sup>f</sup> : 61 in 53 (deaths: 4 procedure-related; 3 unknown relatedness; 3 pending adjudication)
HR (95% CI)	0.71 (0.44 to 1.1) <sup>e</sup> 0.37 (0.27 to 0.52) <sup>g</sup>	NA	NA	NA
<b>El-Chami et al (2024)<sup>56</sup>,</b>				
N	NA	NA	60 months 1809	60 months 1809
Micra	NA	NA	<ul style="list-style-type: none"> <li>Death: 676 (5-year mortality rate: 39.5%)</li> </ul>	4.47% (95% CI, 3.6% to 5.5%)
<b>Micra CED Study</b>				
	30 days and 6 months	NA	NA	30 days and 6 months
<b>Piccini et al (2021)<sup>58</sup>,</b>				
N	5746	NA	NA	5746
Micra complication rate, RR or HR (95% CI)	30-d, unadjusted: NR 30-d, adjusted: 0.3 (-0.6 to 1.3) 6-mo, unadjusted: 0.84 (0.68 to 1.03) 6-mo, adjusted:	NA	NA	Acute (30 days), n (%): <ul style="list-style-type: none"> <li>Overall: 484 in 5746 patients (8.4)</li> <li>Embolism and thrombosis, 202 (3.5)</li> <li>Events at puncture site, 78 (1.4)</li> <li>Cardiac effusion and/or perforation, 47 (0.8)</li> <li>Device-related complication, 81 (1.4)</li> <li>Other complications, 136 (2.4)</li> </ul> 6-Month CIF Estimates, % (95% CI)

Study	Freedom From System- or Procedure-Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
	0.77 (0.62 to 0.96)			<ul style="list-style-type: none"> <li>Overall: 3.2 (2.9 to 3.6)</li> <li>Embolism and thrombosis: &lt;10 events</li> <li>Device-related complications: 1.7 (1.5 to 1.9)</li> <li>Other complications: 1.6 (1.3 to 1.8)</li> </ul>
• 24 months <sup>h</sup>	NA	NA	NA	24 months <sup>i</sup>
El-Chami et al (2022) <sup>59</sup>	6219 (Micra)	NA	NA	6219 (Micra)
N	10,212 (transvenous)	NA	NA	10,212 (transvenous)
Micra	adjusted, 3.1%	NA	NA	Chronic complications CIF Estimates, % (95% CI) <ul style="list-style-type: none"> <li>Overall: 4.6 (4.2 to 4.9)</li> <li>Embolism and thrombosis: &lt;10 events</li> <li>Device-related complications: 2.4 (2.2 to 2.5)</li> <li>Other complications: 2.1 (2.0 to 2.3) <ul style="list-style-type: none"> <li>Pericarditis: 1.6 (1.4 to 1.9)</li> </ul> </li> </ul>
Transvenous	adjusted, 4.9%	NA	NA	Chronic complications CIF Estimates, % (95% CI) <ul style="list-style-type: none"> <li>Overall: 6.5 (6.1 to 6.9)</li> <li>Embolism and thrombosis: 0.2 (0.2 to 0.2)</li> <li>Device-related complications: 4.8 (4.7 to 5.0)</li> <li>Other complications: 1.4 (1.3 to 1.6) <ul style="list-style-type: none"> <li>Pericarditis: 0.8 (0.7 to 0.9)</li> </ul> </li> </ul>
RR or HR (95% CI)	adjusted, 0.62 (0.45 to 0.85)	NA	NA	Relative risk reduction (95% CI) <ul style="list-style-type: none"> <li>Overall: 31 (19 to 40)</li> <li>Embolism and thrombosis: 46 (-17 to 75)</li> <li>Device-related complications: 52 (42 to 60)</li> <li>Other complications: -48 (-91 to -15) <ul style="list-style-type: none"> <li>Pericarditis: -105 (-180 to -50)</li> </ul> </li> </ul>
36 months <sup>h</sup>	NA	NA	NA	36 months <sup>i</sup>
Crossley et al (2023) <sup>61</sup>	6219 (Micra)	NA	NA	6219 (Micra)
N	10,212 (transvenous)	NA	NA	10,212 (transvenous)
Micra	adjusted, 3.6%	NA	NA	Chronic complications CIF Estimates, % (95% CI) <ul style="list-style-type: none"> <li>Overall: 4.9 (4.6 to 5.2)</li> <li>Embolism and thrombosis: &lt;11 events</li> </ul>

Study	Freedom From System- or Procedure- Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
				<ul style="list-style-type: none"> <li>• Device-related complications: 2.6 (2.5 to 2.7)</li> <li>• Other complications: 2.1 (2.0 to 2.2) <ul style="list-style-type: none"> <li>○ Pericarditis: 1.7 (1.4 to 1.9)</li> <li>○ Hemothorax: 0.7 (0.6 to 0.8)</li> </ul> </li> </ul>
Transvenous	adjusted, 6.0%	NA	NA	Chronic complications CIF Estimates, % (95% CI) <ul style="list-style-type: none"> <li>• Overall: 7.1 (6.7 to 7.6)</li> <li>• Embolism and thrombosis: 0.3 (0.3 to 0.3)</li> <li>• Device-related complications: 5.2 (5.1 to 5.3)</li> <li>• Other complications: 1.5 (1.4 to 1.6) <ul style="list-style-type: none"> <li>○ Pericarditis: 0.9 (0.8 to 1.0)</li> <li>○ Hemothorax: 0.9 (0.7 to 1.0)</li> </ul> </li> </ul>
RR or HR (95% CI)	adjusted, 0.41 (0.22 to 0.56)	NA	NA	Relative risk reduction (95% CI) <ul style="list-style-type: none"> <li>• Overall: 32 (22 to 41)</li> <li>• Embolism and thrombosis: 56 (6 to 79)</li> <li>• Device-related complications: 51 (41 to 59)</li> <li>• Other complications: -39 (-76 to -9) <ul style="list-style-type: none"> <li>○ Pericarditis: -93 (-161 to -42)</li> <li>○ Hemothorax: 22 (-18 to 48)</li> </ul> </li> </ul>
<b>Micra AV AccelAV Study</b>				
	3 months	NA	NA	3 months
<b>Chinitz et al (2022)<sup>37</sup></b>				
N	54; 152j	NA	NA	54; 152j
Micra AV	Overall (n=152): 90.8%	NA	NA	Events, n (%) - Overall <ul style="list-style-type: none"> <li>• Total events: 14/152 (9.2)</li> <li>• Cardiac effusion/perforation: 4 (2.6)</li> <li>• Elevated threshold: 1 (0.7)</li> <li>• Cardiac rhythm disorder: 4 (2.6)</li> <li>• Other: 5 (3.3)</li> </ul> Events, n (%) - Intended Use <ul style="list-style-type: none"> <li>• Total events: 5/54 (9.3)</li> <li>• Cardiac effusion/perforation: 0 (0)</li> <li>• Elevated threshold: 1 (1.9)</li> <li>• Cardiac rhythm disorder: 1 (1.9)</li> <li>• Other: 3 (5.6)</li> </ul>
<b>Micra AV Coverage with Evidence Development Study</b>				
	NA	NA	NA	30 days and 6 months
<b>Crossley et al (2024)<sup>62</sup></b>				

Study	Freedom From System- or Procedure-Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
N	NA	NA	NA	Micra AV (n=7471); Dual chamber transvenous pacemaker (n=107,800)
Micra AV	NA	NA	NA	<p>30-day acute complications adjusted rates (%):</p> <ul style="list-style-type: none"> <li>• Overall complications: 8.6</li> <li>• Embolism and thrombosis: 4.0</li> <li>• Events at the puncture site: 0.9</li> <li>• Cardiac effusion/perforation: 1.4</li> <li>• Device-related complication: 1.4</li> <li>• Other complications: 2.1</li> <li>• All-cause mortality: 6.0</li> </ul> <p>6-month chronic complications weighted CIF estimates (95% CI):</p> <ul style="list-style-type: none"> <li>• Overall complications: 3.5% (3.4% to 3.7%)</li> <li>• Embolism and thrombosis: 0.2% (0.2% to 0.2%)</li> <li>• Device-related complications: 2.2% (2.2% to 2.3%)</li> <li>• Other complications: 1.7% (1.6% to 1.7%) <ul style="list-style-type: none"> <li>○ Pericarditis: 1.2% (1.1% to 1.3%)</li> <li>○ Hemothorax: 0.4% (0.4% to 0.5%)</li> </ul> </li> </ul>
Dual chamber transvenous pacemaker	NA	NA	NA	<p>30-day acute complications adjusted rates (%):</p> <ul style="list-style-type: none"> <li>• Overall complications: 11.0</li> <li>• Embolism and thrombosis: 3.7</li> <li>• Events at the puncture site: 0.5</li> <li>• Cardiac effusion/perforation: 0.8</li> <li>• Device-related complication: 4.1</li> <li>• Other complications: 3.0</li> <li>• All-cause mortality: 3.5</li> </ul> <p>6-month chronic complications weighted CIF estimates (95% CI):</p> <ul style="list-style-type: none"> <li>• Overall complications: 7.0% (6.7% to 7.3%)</li> <li>• Embolism and thrombosis: 0.2% (0.2% to 0.2%)</li> <li>• Device-related complications: 5.9% (5.8% to 5.9%)</li> <li>• Other complications: 1.7% (1.6% to 1.7%) <ul style="list-style-type: none"> <li>○ Pericarditis: 1.2% (1.1% to 1.3%)</li> <li>○ Hemothorax: 0.5% (0.4% to 0.6%)</li> </ul> </li> </ul>

Study	Freedom From System- or Procedure-Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
RR or HR (95% CI)	NA	NA	NA	6-month relative risk reduction (95% CI): <ul style="list-style-type: none"> <li>Overall complications: 50% (43% to 57%)</li> <li>Embolism and thrombosis: -6% (-86% to 40%)</li> <li>Device-related complications: 62% (56% to 68%)</li> <li>Other complications: 1% (-20% to 18%) <ul style="list-style-type: none"> <li>Pericarditis: 4% (-23% to 26%)</li> <li>Hemothorax: 15% (-24% to 42%)</li> </ul> </li> </ul>
<b>MAP EMEA Registry</b>				
	NA	NA	12 months	30 days and 12 months
<b>Roberts et al (2023)<sup>57</sup></b>				
N	NA	NA	928	928
Micra VR	NA	NA	<ul style="list-style-type: none"> <li>Death: 127</li> <li>Permanent loss of device function due to mechanical or electrical dysfunction of the device: NR</li> <li>Hospitalization : NR</li> <li>Prolonged hospitalization by 48 hours or more: NR</li> <li>System revision: 11</li> </ul>	30 days: <ul style="list-style-type: none"> <li>Total events: 24 (2.69%; 95% CI: 1.66 to 3.82%)</li> <li>Events at the groin and puncture site: 10</li> <li>Cardiac effusion/perforation events: 6</li> <li>Device pacing issues: 4</li> <li>Infection events: 3</li> <li>hemodynamic instability: 1</li> </ul> 12 months: <ul style="list-style-type: none"> <li>Events after 30 days: 11</li> </ul>
<b>MAP Japan</b>				
	NA	NA	6 months	30 days and 6 months
<b>Ando et al (2023)<sup>71</sup></b>				
N	NA	NA	300	300
Micra VR	NA	NA	<ul style="list-style-type: none"> <li>Death: 22</li> <li>Permanent loss of device function due to mechanical or electrical dysfunction of the device: NR</li> <li>Hospitalization : NR</li> <li>Hospitalization ≥48 hours: NR</li> </ul>	30 days, n (number of patients, %): <ul style="list-style-type: none"> <li>Total major complications: 11 (10, 3.33%)</li> <li>Thrombosis: 2 (2, 0.67%)</li> <li>Events at groin puncture site: 2 (1, 0.33%)</li> <li>Cardiac effusion/perforation: 3 (3, 1.00%)</li> <li>Pacing issues: 4 (4, 1.33%)</li> </ul> 6 months, n (%): <ul style="list-style-type: none"> <li>Total major complications: 11 (10, 3.33%)</li> <li>Thrombosis: 2 (2, 0.67%)</li> </ul>

Study	Freedom From System- or Procedure-Related Major Complications	Percentage of Patients with Adequate Pacing Capture Thresholds	Major Complications Criteria, n (%)	Major Complications, n (%)
Aveir LEADLESS II IDE Trial			<ul style="list-style-type: none"> <li>System revision: NR</li> </ul>	<ul style="list-style-type: none"> <li>Events at groin puncture site: 2 (1, 0.33%)</li> <li>Cardiac effusion/perforation: 3 (3, 1.00%)</li> <li>Pacing issues: 4 (4, 1.33%)</li> </ul>
	6 Weeks	6 Weeks	NR	6 Weeks
	6 Months	6 Months		
	FDA SSSED (2022); PMA P150035 <sup>29</sup> ; Reddy et al (2021) <sup>27</sup> .			
N	200	200	NR	200
Aveir	0.960 (0.922 to 0.982); 0.933 (0.898 to 0.956)	0.959 (0.921 to 0.982); 0.934 (0.899 to 0.960)	NR	SADEs: 9 in 8 patients (4.0% [95% CI, NR]) <ul style="list-style-type: none"> <li>Cardiac perforation/tamponade: 3 (1.5)</li> <li>Premature deployment with migration: 2 (1.0)</li> <li>Premature deployment without migration: 1 (0.5)</li> <li>Vascular access site complication - bleeding: 1 (0.5)</li> <li>Embolism: 1 (0.5)</li> <li>Thrombosis: 0.5</li> </ul>
•	1 year	1 year	NR	1 year
Reddy et al (2023) <sup>77</sup> .				
N	210	210	NR	210
Aveir	0.932 (0.887 to 0.959)	0.915 (0.912 to 0.976)	NR	SADEs: 15 in 14 patients (6.7% [95% CI, NR]) <ul style="list-style-type: none"> <li>Cardiac perforation/tamponade/pericardial effusion: 4 (1.9)</li> <li>Premature deployment with or without migration: 3 (1.5)</li> <li>Vascular access site bleeding event: 2 (1.0)</li> <li>Heart failure: 2 (1.0)</li> <li>Pacemaker-induced cardiomyopathy: 2 (1.0)</li> <li>Pulmonary embolism: 1 (0.5)</li> <li>DVT: 1 (0.5)</li> </ul>

CED: coverage with evidence development; CI: confidence interval; CIF: cumulative incidence function; DVT: deep vein thrombosis; FDA: U.S. Food and Drug Administration; HR: hazard ratio; IDE: investigational device exemption; MAP EMEA: Micra Acute Performance European and Middle Eastern; NA: not available; NR: not reported; OR: odds ratio; PMA: premarket approval; RR: relative risk; SADE: serious adverse device effects; SSSED: Summary of Safety and Effectiveness Data; TE: thromboembolism; TMC: Total major complication.

<sup>a</sup> Total number of patients who received the implant successfully.

<sup>b</sup> Number of patients for whom data were available for 6-month evaluation.

<sup>c</sup> Device explant, reposition, or replacement.

<sup>d</sup> Calculations performed by BCBSA based on the major complication rate (2.7%; 95% CI 2.0% to 3.6%) reported by El-Chami et al (2018).

<sup>e</sup> Major complication vs. IDE trial.

<sup>f</sup> Unclear if the complications met the definition of a major complication as events leading to death, hospitalization, prolonged hospitalization by 48 hours, system revision, or loss of device therapy.

<sup>g</sup> Major complication vs. historical controls.

<sup>h</sup> Device reintervention rate.

<sup>i</sup> Chronic complications.

<sup>j</sup> Overall safety and intended use (n=54) subpopulation.

### Aveir Postapproval Experience

Continued FDA approval of the Aveir transcatheter pacing system is contingent on the results of the Aveir VR Real-World Evidence Study.<sup>80</sup> This post-approval study is designed to evaluate the long-term safety of the Aveir device in a real-world sample of 2100 participants. Both acute and long-term safety will be evaluated as post implant complication-free rates at 30-days and 10-years. Six-month data were submitted to the FDA in September 2022 but have not yet been published as of March 2023. Ten-year reports are due in March 2032.

Garg et al (2023) analyzed data from the FDA MAUDE database to capture adverse events associated with the Aveir VR device.<sup>81</sup> The database was queried on January 20, 2023 and there were a total of 98 medical device reports for the Aveir VR. They excluded duplicate, programmer-related, and introducer-sheath-related entries (n=34), so 64 entries were included in the final analysis. The most common reported events were high threshold/noncapture (28.1%, n=18), stretched helix (17.2%, n=11), device dislodgement (15.6%, n=10), and device separation failure (14.1%, n=9). Other reported events included high impedance (14.1%, n=9), sensing issues (12.5%, n=8), bent/broken helix (7.8%, n=5), premature separation (4.7%, n=3), interrogation problem (3.1%, n=2), low impedance (3.1%, n=2), premature battery depletion (1.6%, n=1), and inadvertent magnetic resonance imaging mode switch (1.6%, n=1). There were 10 miscellaneous events (15.6%). There were 8 serious patient injury events, including pericardial effusion requiring pericardiocentesis (7.8%, n=5) due to cardiac perforation, resulting in 2 deaths (3.1%), and sustained ventricular arrhythmias (4.6%, n=3). Overall, this study demonstrated that serious adverse events occurred, including life-threatening ventricular arrhythmias, pericardial effusion, device explantation/reimplantation, and death.

Tables 9 and 10 display notable limitations identified for key studies.

**Table 9. Study Relevance Limitations**

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Follow-Up <sup>e</sup>
<b>Micra</b>					
Reynolds et al (2016) <sup>46</sup> ; Duray et al (2017) <sup>9</sup> .			2. This was a single cohort study; there was no comparator		1-2. Insufficient duration for benefit and harms
Roberts et al (2017) <sup>51</sup> ; El-Chami et al (2018) <sup>53</sup> .			2. This was a single cohort study; there was no comparator		1-2. Insufficient duration for benefit and harms
Piccini et al (2021) <sup>58</sup> .	1. It is unclear whether all patients were considered medically eligible for a transvenous device.				1-2: Insufficient duration for benefit and harms
El-Chami et al (2022) <sup>59</sup> .	1. It is unclear whether all				1-2. Insufficient

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Follow-Up <sup>e</sup>
	patients were considered medically eligible for a transvenous device.				duration for benefit and harms
Crossley et al (2023) <sup>61</sup> ,	1. It is unclear whether all patients were considered medically eligible for a transvenous device.				1-2. Insufficient duration for benefit and harms
Chinitz et al (2022) <sup>37</sup> ,	1. Approximately 25% of patients were not considered medically eligible for a transvenous device		2. This was a single cohort study; there was no comparator	1. Outcomes not stratified by medical eligibility; 5. Clinically significant difference for atrioventricular synchrony not known	1-2. Insufficient duration for benefit and harms
El-Chami et al (2024) <sup>56</sup> ,			2. This was a single cohort study; there was no comparator		
Garweg et al (2023) <sup>42</sup> ,					1-2. Insufficient duration for benefit and harms
Roberts et al (2023) <sup>57</sup> ,			2. This was a single cohort study; there was no comparator		1-2. Insufficient duration for benefit and harms
Ando et al (2023) <sup>71</sup> ,			2. This was a single cohort study; there was no comparator		1-2. Insufficient duration for benefit and harms
Crossley et al (2024) <sup>62</sup> ,			2. Not standard or optimal; comparator from Medicare claims data		1-2. Insufficient duration for benefit and harms
Aveir FDA SSED (2022); PMA P150035 <sup>29</sup> ; Reddy et al (2021) <sup>27</sup> ,			2. This was a single cohort study; there was no comparator	1. Survival data not based on currently marketed device; quality of life	1-2. Insufficient duration for benefit and harms

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Follow-Up <sup>e</sup>
Reddy et al (2023) <sup>77</sup>			2. This was a single cohort study; there was no comparator	outcomes are not available 1. Survival data and quality of life outcomes not reported	1-2. Insufficient duration for benefit and harms

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

<sup>b</sup> Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

<sup>c</sup> Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

<sup>d</sup> Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

<sup>e</sup> Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

**Table 10. Study Design and Conduct Limitations**

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
<b>Micra</b>						
Reynolds et al (2016) <sup>46</sup> ; Duray et al (2017) <sup>79</sup>	1. Participants not randomly allocated; design was prospective single cohort study	1. Not blinded to treatment assignment; 2. Not blinded outcome assessment. However, adverse events analyzed by an independent clinical event committee. Trial oversight provided by an independent data and safety monitoring committee.				
Roberts et al (2017) <sup>51</sup> ; El-Chami et al (2018) <sup>53</sup>	1. Participants not randomly allocated; design was prospective registry	1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician				
Piccini et al (2021) <sup>58</sup>	1. Participants not randomly allocated; design was prospective registry	1. Not blinded to treatment assignment; 2. Outcome assessment not described.				
El-Chami et al (2022) <sup>59</sup>	1. Participants not randomly allocated; design was prospective registry	1. Not blinded to treatment assignment; 2. Outcome assessment not described.				

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Crossley et al (2023) <sup>61</sup> ,	1. Participants not randomly allocated; design was prospective registry	1. Not blinded to treatment assignment; 2. Outcome assessment not described.				
Chinitz et al (2022) <sup>57</sup> ,	1. Participants not randomly allocated; design was prospective single cohort study	1. Not blinded to treatment assignment; 2. Blinding of outcome assessment unclear.				
El-Chami et al (2024) <sup>56</sup> ,	1. Participants no randomly allocated; design was prospective single cohort study	1. Not blinded to treatment assignment; 2. Blinding of outcome assessment no described.				
Garweg et al (2023) <sup>42</sup> ,		1. Not blinded to treatment assignment; 2. Blinding of outcome assessment no described.				
Roberts et al (2023) <sup>57</sup> ,	1. Participants not randomly allocated; design was prospective single-arm study	1. Not blinded to treatment assignment; 2. Blinding of outcome assessment no described.				
Ando et al (2023) <sup>71</sup> ,	1. Participants not randomly allocated; design was prospective single-cohort study	1. Not blinded to treatment assignment; 2. Blinding of outcome assessment no described.				
Crossley et al (2024) <sup>62</sup> ,	1. Participants not randomly allocated; design was prospective registry	1. Not blinded to treatment assignment; 2. Blinding of outcome assessment no described.				
Aveir						

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
FDA SED (2022); PMA 1. P150035 <sup>29</sup> ; Reddy et al (2021) <sup>27</sup> .	1. Participants not randomly allocated; design was prospective single cohort	1. Not blinded to treatment assignment; 2-3. Blinding of outcome assessment not described				
Reddy et al (2023) <sup>77</sup> .	1. Participants not randomly allocated; design was prospective single cohort	1. Not blinded to treatment assignment; 2-3. Blinding of outcome assessment not described				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

<sup>b</sup> Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

<sup>c</sup> Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

<sup>d</sup> Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

<sup>e</sup> Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

<sup>f</sup> Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

### Comparison of Micra and Aveir Devices

Tam et al (2024) conducted a non-randomized retrospective analysis of pacing threshold performance on the Aveir VR (n=123) compared to the Micra VR (n=139).<sup>82</sup> The primary endpoint was pacing threshold at various time points before, during, and through 3 months after the procedure. High pacing threshold was defined as  $\geq 1.5$  V at 0.4 ms for the Aveir VR and  $\geq 1.5$  V at 0.24 ms for the Micra VR. At the end of the procedure, more individuals in the Aveir VR group had a high pacing threshold (11.5%) compared to in the Micra VR group (2.2%) ( $p=.004$ ). At 3 months, there was no difference in the probability of a high pacing threshold between the Aveir VR group (2.3%) and the Micra VR group (3.1%) ( $p=1.000$ ). The authors note the Aveir VR demonstrated satisfactory performance, however the study was limited by its small sample size and lack of randomization.

### Section Summary: Ventricular Pacing for Individuals Who Are Medically Eligible for a Conventional Pacing System

The evidence for use of the Micra transcatheter pacing system consists of a systematic review, a pivotal prospective cohort study, a postapproval prospective cohort study, a Medicare registry, and a retrospective FDA database analysis. Results at 6 months and 1 year for the pivotal study reported high procedural success (>99%) and device effectiveness (pacing capture threshold met in 98% of patients). Most of the system- or procedural-related complications occur within 30 days. At 1 year, the incidence of major complications did not increase substantially from 6 months (3.5% at 6 months vs. 4% at 1 year). Results of the postapproval study were consistent with a pivotal study and showed a lower incidence of major complications up to 30 days postimplantation and 1 year (1.5% and 2.7%, respectively). In both studies, the point estimates of major complications were lower than the pooled

estimates from 6 studies of conventional pacemakers used as a historical comparator. While the Micra transcatheter pacing system eliminates adverse events associated with lead and pocket issues, its use results in additional complications related to the femoral access site (groin hematomas, access site bleeding) and implantation and release of the device (traumatic cardiac injury). Initial data from a Medicare registry found a significantly higher rate of pericardial effusion and/or perforation within 30 days in patients with the leadless Micra pacemaker compared to patients who received a transvenous device; overall 6-month complication rates were significantly lower in the Micra group in the adjusted analysis ( $p=.02$ ). In a real-world study of Medicare patients, the Micra device was associated with a 41% lower rate of reinterventions and a 32% lower rate of chronic complications compared with transvenous pacing, with no significant difference in adjusted all-cause mortality at 3 years despite the higher comorbidity index for patients implanted with a Micra device. However, patients receiving the Micra device experienced significantly more other complications, driven by higher rates of pericarditis. No significant differences were noted in the composite endpoint of time to heart failure hospitalization or death for the full cohort ( $p=.28$ ) or the subgroup without a history of heart failure ( $p=.98$ ). It is also unclear whether all patients were considered medically eligible for a conventional pacing system. A 2021 analysis of the FDA MAUDE database revealed significantly higher rates of death, cardiac tamponade, and rescue thoracotomy in Micra recipients compared to patients implanted with a transvenous pacemaker ( $p<.001$ ), although this study is limited by potential risk of ascertainment bias. A single-arm study of the Micra AV device reported that 85.2% of individuals with complete AV block and normal sinus rhythm successfully achieved a  $>70\%$  resting AVS rate at 1 month postimplant and that AVS rates could be further enhanced with additional device programming. However, clinically meaningful rates of AVS are unknown. Longer-term device characterization is planned in the Micra AV Post-Approval Registry through 3 years. The evidence for the use of the Aveir transcatheter pacing system consists of a pivotal prospective cohort study. Primary safety and efficacy outcomes at 6 weeks exceeded performance goals for complication-free rate and composite success rate (96.0% and 95.9%, respectively). Results at 6 months were similar and at 1 year were 93.2% and 91.5%, respectively. Incidence of major complications at 1 year was 6.7% compared to 4.0% at 6 months. The 2-year survival estimate of 85.3% is based on Phase 1 performance with the predecessor Nanostim device.

Considerable uncertainties and unknowns remain in terms of the durability of the devices and end-of-life device issues. Early and limited experience with the Micra device has suggested that retrieval is unlikely because in due course of time, the device will be encapsulated. There are limited data on device-device interactions (both electrical and mechanical), which might occur when there is a deactivated Micra device alongside another leadless pacemaker or when a leadless pacemaker and transvenous device are both present. While the Aveir device is specifically designed to be retrieved when therapy needs evolve or the device needs to be replaced, clinical experience with device retrieval is limited to case reports.

### **Ventricular Pacing for Individuals who are Medically Ineligible for a Conventional Pacing System Clinical Context and Therapy Purpose**

The purpose of single-chamber transcatheter pacing systems in individuals with a class I or II guidelines-based indication for implantation of a single-chamber ventricular pacemaker is to provide a treatment option that is an alternative to or an improvement on conventional pacing systems.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with a class I or II guidelines-based indication for implantation of a single-chamber ventricular pacemaker who are medically ineligible for a conventional pacing system.

### **Interventions**

The therapy being considered is a single-chamber transcatheter pacing system (e.g., Micra, Aveir).

### **Comparators**

The following therapy and practice are currently being used to make decisions about managing individuals ineligible for a conventional pacemaker: medical management and/or conventional single-chamber pacemakers placed via trans-iliac venous lead placement or surgical epicardial pacemaker.

### **Outcomes**

The general outcomes of interest are treatment-related mortality and morbidity. Specifically, the short-term outcomes include acute complication-free survival rate, the electrical performance of the device, including the pacing capture threshold, and adverse events, including procedural and postprocedural complications. Long-term outcomes include chronic complication-free survival rate, the electrical performance of the device, including pacing impedance, and pacing thresholds and chronic complications, including any system explant, replacement (with and without system explant), and repositions. Further, analysis of summary statistics regarding battery length is important.

To assess short-term safety, the first 30 days postimplant is generally considered appropriate because most device and procedural complications occur within this time frame. To assess long-term efficacy and safety as well as issues related to device end-of-life, a follow-up to 9 to 12 years postimplant with an adequate sample size are required to characterize device durability and complications with sufficient certainty.

### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies on the currently marketed version of the technology were sought.
- Studies with duplicative or overlapping populations were excluded.

### **Review of Evidence**

#### **Nonrandomized Controlled Trials**

No studies that exclusively enrolled individuals who were medically ineligible to receive a conventional pacing system were identified.

#### **Micra Leadless Pacemaker**

In the IDE trial, 6.2% or 45 patients received the Micra Transcatheter Pacing System because they were medically ineligible for a conventional pacing system due to compromised venous access, the need to preserve veins for hemodialysis, thrombosis, a history of infection, or the need for an indwelling venous catheter. A stratified analysis of these 45 patients was not presented in the originally published paper<sup>46</sup>, or the FDA documents.<sup>11,83,28,48</sup>

In the post approval registry, the authors reported stratified results for 105 of 1820 patients who had previous cardiac implantable electronic device (CIED) infection.<sup>84</sup> Of these 105, 83 patients (79%) were classified as medically ineligible to receive a conventional pacemaker in the opinion of the physician. A stratified analysis of these 83 patients was not presented in the publication. Trial characteristics and results are summarized in Tables 11 and 12, respectively. In this cohort of patients with CIED infection, the Micra device was implanted successfully in 104 patients and the previous CIED was explanted the same day as the Micra device was implanted in 37% of patients. Major

complications were reported in 3.8% of patients with an average follow-up of 8.5 months. Ten deaths were reported (14% at 12 months) but none were related to the Micra transcatheter pacing system or the implantation procedure.

Garg et al (2020) conducted a post-hoc analysis on safety and all-cause mortality outcomes for 546 patients enrolled in the Micra IDE study, the Micra Continued Access (CA) study, and the Micra Post-Approval Registry who were deemed ineligible for conventional pacing system implantation.<sup>85</sup> Most common reasons for conventional pacing system ineligibility included impaired venous access (42.5%) and history of device infection or bacteremia (38.8%). Implant success rates were >99% for both medically ineligible and nonprecluded subgroups implanted with Micra devices. Both acute mortality (2.75% vs. 1.32%;  $p=.022$ ) and total mortality at 36 months (38.1% vs. 20.6%;  $p<.001$ ) were significantly higher in the medically ineligible group compared to the nonprecluded Micra group. Mortality was also significantly higher in the medically ineligible group compared to a historical cohort implanted with a conventional transvenous pacing system (38.1% vs. 23.2%). The rate of acute major complications (2.93% vs. 2.47%;  $p=.55$ ) and total major complications through 36 months (4.30% vs. 3.81%;  $p=.40$ ) was not significantly different between the medically ineligible and nonprecluded Micra groups, respectively. The authors emphasized that the elevated rate of all-cause mortality may be related to a higher incidence of chronic comorbidities in the medically ineligible population, such as diabetes, renal dysfunction, and current dialysis treatment, which may have increased overall mortality risk during follow-up. The majority of medically ineligible patients were enrolled in the CA and Post-Approval Registry studies, which unlike the IDE study, did not exclude patients with a life expectancy <12 months.

**Table 11. Summary of Key Nonrandomized Trial Characteristics in Patients Ineligible for a Conventional Pacing System and/or Previous Cardiac Implantable Electronic Device Infection**

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up, mo
El-Chami et al (2018) <sup>84</sup> ; NCT02536118	Prospective single cohort (Micra Post-Approval Registry)	23 countries in North America, Europe, Asia, Australia, and Africa	2016-2018	Any patient to be implanted with a Micra with a CIED infection	Micra pacemaker (N=105)	8.5 (range, 0 to 28.5)
Garg et al (2020) <sup>85</sup> .	Post hoc analysis of prospectively collected data from Micra studies	Multinational	NR	Any patient in a Micra study considered ineligible for a conventional pacing system	Micra pacemaker (N=546)	23.5 ± 14.7

CIED: cardiac implantable electronic device; NCT: national clinical trial; NR: not reported.

**Table 12. Summary of Key Nonrandomized Trial Results in Patients Ineligible for a Conventional Pacing System and/or Previous Cardiac Implantable Electronic Device Infection**

Study	No. of Patients With System- or Procedure-Related Major Complications at 1 Year, % (n/N)	Average Pacing Threshold at 1 Year	Major Complications at 1 Year
El-Chami et al (2018) <sup>84</sup> .			
N	105	82	105
Micra	4 (4/105)	0.6 V	Total major complications: 6 in 4 patients; (patient 1: effusion requiring pericardiocentesis; patient 2: elevated thresholds, complication of device removal [IVC filter entanglement], and subsequent abdominal wall

Study	No. of Patients With System- or Procedure-Related Major Complications at 1 Year, % (n/N)	Average Pacing Threshold at 1 Year	Major Complications at 1 Year
			infection, patients 3 and 4: pacemaker syndrome)
Garg et al (2020) <sup>85</sup> ,			
N	546	NR	546
Micra	4 (22/546) <sup>a</sup>	NR	Total major complications: 24 in 22 patients; (4 cases cardiac effusion/perforation, 4 events at groin puncture site, 1 case of thrombosis, 4 cases of pacing issues, 1 case of cardiac rhythm disorder, 3 cases of infection, and 7 other)

IVC: inferior vena cava filter; NR: not reported.

<sup>a</sup> Outcome reported at 36 months.

Tables 13 and 14 display notable limitations identified in selected studies.

**Table 13. Study Relevance Limitations**

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Follow-Up <sup>e</sup>
El-Chami et al (2018) <sup>84</sup> ,			2. This was a single cohort study; there was no comparator		1. Insufficient duration for benefit; 2. Insufficient duration for harms
Garg et al (2020) <sup>85</sup> ,					1. Insufficient duration for benefit; 2. Insufficient duration for harms

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

<sup>b</sup> Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

<sup>c</sup> Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

<sup>d</sup> Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

<sup>e</sup> Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

**Table 14. Study Design and Conduct Limitations**

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup> Statistical <sup>f</sup>
El-Chami et al (2018) <sup>84</sup> ,	1. Participants not randomly allocated; design was prospective registry	1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician			

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Garg et al (2020) <sup>95</sup> ,	1. Participants not randomly allocated; post-hoc analysis	1-3. Blinding and outcome assessment not described.				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

<sup>b</sup> Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

<sup>c</sup> Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

<sup>d</sup> Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

<sup>e</sup> Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

<sup>f</sup> Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

### Section Summary: Ventricular Pacing for Individuals Who Are Medically Ineligible for a Conventional Pacing System

No studies that exclusively enrolled patients who were medically ineligible for a conventional pacing system were identified. However, a subgroup of patients in whom the use of conventional pacemakers was precluded was enrolled in the pivotal and the postapproval trials of the Micra device. Information on the outcomes in these subgroups of patients from the post approval study showed that Micra was successfully implanted in 98% to 99% of cases and safety outcomes were similar to the original cohort. Even though the evidence is limited, and long-term effectiveness and safety are unknown, the short-term benefits may outweigh the risks because the complex trade-off of adverse events for these devices needs to be assessed in the context of the life-saving potential of pacing systems in patients ineligible for conventional pacing systems.

### Dual-Chamber Pacing for Individuals Who are Medically Eligible for a Conventional Pacing System

#### Clinical Context and Therapy Purpose

The purpose of dual-chamber pacing systems in individuals with a class I or II guidelines-based indication for implantation of a dual-chamber pacemaker is to provide a treatment option that is an alternative to or an improvement on conventional pacing systems.

The following PICO was used to select literature to inform this review.

#### Populations

The relevant population of interest is individuals with a class I or II guidelines-based indication for implantation of a dual-chamber pacemaker who are medically eligible for a conventional pacing system.

#### Interventions

The therapy being considered is a dual-chamber pacing system (e.g., Aveir).

#### Comparators

The following therapy is currently being used to make decisions about managing individuals requiring a pacemaker: a conventional dual-chamber pacemaker.

### **Outcomes**

The general outcomes of interest are treatment-related mortality and morbidity. Specifically, the short-term outcomes include acute complication-free survival rate, the electrical performance of the device, including the pacing capture threshold, and adverse events, including procedural and postprocedural complications. Long-term outcomes include chronic complication-free survival rate, the electrical performance of the device, including pacing impedance and pacing thresholds, and chronic complications, including any system explant, replacement (with and without system explant), and repositions. Further, analysis of summary statistics regarding battery length is important.

To assess short-term safety, the first 30 days postimplant is generally considered appropriate because most device and procedural complications occur within this time frame. To assess long-term efficacy and safety as well as issues related to device end-of-life, a follow-up to 9 to 12 years postimplant with an adequate sample size are required to characterize device durability and complications with sufficient certainty.

### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies on the currently marketed version of the technology were sought.
- Studies with duplicative or overlapping populations were excluded.

### **Nonrandomized Controlled Trials**

#### **Aveir Leadless Pacemaker**

#### **Pivotal Trial**

The pivotal trial was a prospective, multicenter, single-group study enrolling 300 individuals to evaluate the safety and performance of the dual-chamber leadless pacemaker system.<sup>86</sup> Inclusion criteria for the study population included having at least 1 clinical indication for device implant based on evidence-based dual chamber pacing guidelines and at least 18 years of age. Results through 3 months post implantation were reported. The primary safety endpoint was freedom from complications and the primary performance endpoint was a combination of adequate atrial capture threshold and sensing amplitude at 3 months. Within 90 days post implantation, there were 35 complications in 29 individuals, of which 28 complications occurred within 2 days post implantation. There were 271 individuals (90.3%; 95% CI, 87.0% to 93.7%) free from complications. Adequate atrial capture threshold and sensing amplitude were met in 90.2% of patients (95% CI, 86.8% to 93.6%). There were 4 deaths reported during follow-up. Study characteristics and results are summarized in Tables 15 and 16. Study limitations are summarized in Tables 17 and 18.

Results from the pivotal trial through 6 months were reported in the Summary of Safety and Effectiveness submitted in the FDA Premarket Approval.<sup>30</sup> At 6 months, 89.1% (95% CI, 85.6% to 92.7%) of individuals were free from complications and adequate atrial capture threshold was met in 90.8% (95% CI, 87.4% to 94.2%) of individuals. Through 6 months there were 4 deaths reported. Study characteristics and results are summarized in Tables 15 and 16. Study limitations are summarized in Tables 17 and 18.

**Table 15. Summary of Key Nonrandomized Trial Characteristics**

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up, mo
Knops et al (2023) <sup>86</sup> ; FDA SSED (2023); PMA P150035 <sup>30</sup> ,	Prospective single cohort	55 centers in United States, Canada, and Europe	2022	Patients who met a guidelines based indication.	Aveir DR dual chamber leadless pacemaker (N=300)	3 <sup>a</sup> 6 <sup>b</sup>

<sup>a</sup> Results from 3-month follow-up reported by Knop et al (2023)<sup>86</sup>,

<sup>b</sup> Results from 6-month follow-up reported in the FDA SSED (2023)<sup>30</sup>,

FDA: Food and Drug Administration; PMA: premarket approval; SSED: Summary of Safety and Effectiveness Data.

**Table 16. Summary of Key Nonrandomized Trial Results**

Study	Freedom from complications, % of patients (95% CI)	Adequate atrial capture threshold and sensing amplitude, % of patients (95% CI)	Complications
	3 months	3 months	3 months
Knops et al (2023) <sup>86</sup> , N	300	300	300
Aveir DR	90.3% (87.0% to 93.7%)	90.2% (86.8% to 93.6%)	Complications, n (number of patients, %): <ul style="list-style-type: none"> <li>• Total: 35 (29, 9.7)</li> <li>• Cardiac arrhythmia: 10 (10, 3.3)</li> <li>• Intermittent or complete loss of implant-to-implant communication: 1 (1, 0.3)</li> <li>• Intraprocedural dislodgement: 6 (5, 1.7)</li> <li>• Postprocedural dislodgement<sup>a</sup>: 5 (5, 1.7)</li> <li>• Urinary retention: 3 (3, 1.0)</li> <li>• Pericardial effusion: 2 (2, 0.7)</li> <li>• Capture threshold issues: 2 (2, 0.7)</li> <li>• Access site bleeding: 1 (1, 0.3)</li> <li>• Retroperitoneal hematoma: 1 (1, 0.3)</li> <li>• Syncope<sup>b</sup>: 1 (1, 0.3)</li> <li>• Heart failure: 1 (1, 0.3)</li> <li>• Oral pain<sup>c</sup>: 1 (1, 0.3)</li> <li>• Pleural effusion: 1 (1, 0.3)</li> </ul>
	6 months	6 months	6 months
FDA SSED (2023); PMA P150035 <sup>30</sup> , N	294	297	300
Aveir DR	89.1% (85.6% to 92.7%)	90.8% (87.4% to 94.2%)	Serious adverse device effects, n (number of patients, %): <ul style="list-style-type: none"> <li>• Cardiac Arrhythmia - Atrial Fibrillation: 9 (9, 3.0)</li> <li>• Device Dislodgement: 5 (5, 1.7)</li> </ul>

Study	Freedom from complications, % of patients (95% CI)	Adequate atrial capture threshold and sensing amplitude, % of patients (95% CI)	Complications
			<ul style="list-style-type: none"> <li>• Inadequate Fixation During Implant Without LP Migration: 3 (2, 0.7)</li> <li>• Urinary Retention: 3 (3, 1.0)</li> <li>• Threshold Elevation: 2 (2, 0.7)</li> <li>• Pericardial Effusion or Rub: 2 (2, 0.7)</li> <li>• Inadequate Fixation During Implant With LP Migration: 2 (2, 0.7)</li> <li>• False Magnet Mode: 1 (1, 0.3)</li> <li>• Syncope: 1 (1, 0.3)</li> <li>• Intermittent Capture: 1 (1, 0.3)</li> <li>• Intermittent or Loss of i2i Communication: 1 (1, 0.3)</li> <li>• Oversensing: 1 (1, 0.3)</li> <li>• Pre-Syncope: 1 (1, 0.3)</li> <li>• Access Site Bleeding Event: 1 (1, 0.3)</li> <li>• Heart Failure: 1 (1, 0.3)</li> <li>• Hematoma Formation, Including Retroperitoneal Hematoma/Hemorrhage: 1 (1, 0.3)</li> <li>• Pain: 1 (1, 0.3)</li> <li>• Pleural Effusion: 1 (1, 0.3)</li> <li>• Pulmonary Embolism: 1 (1, 0.3)</li> <li>• Mechanical Device Dislodgement: 1 (1, 0.3)</li> <li>• Complete AV Block: 1 (1, 0.3)</li> </ul>

AV: atrioventricular; CI: confidence interval; FDA: Food and Drug Administration; LP: leadless pacemaker; PMA: premarket approval; SSED: Summary of Safety and Effectiveness Data.

<sup>a</sup> All dislodgements after the implantation procedure were dislodgements of atrial leadless pacemakers. The count excludes 1 additional atrial leadless pacemaker mechanical dislodgement that occurred during a coronary artery bypass surgery that was not related to the study. The device was successfully retrieved, and the event was not considered to be device- or procedure-related by the clinical events committee.

<sup>b</sup> Syncope resulted in fracture of the patient's right distal phalanx.

<sup>c</sup> Oral pain after the procedure, possibly a result of oral instrumentation associated with anesthesia, led to tooth extraction

Tables 17 and 18 display notable limitations identified in selected studies.

**Table 17. Study Relevance Limitations**

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-up <sup>e</sup>
Knops et al (2023) <sup>86</sup> ; FDA SSED (2023); PMA P150035 <sup>30</sup> .			2. This was a single cohort study; there		1-2. Insufficient duration for

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-up <sup>e</sup>
			was no comparator		benefit and harms

FDA: Food and Drug Administration; PMA: premarket approval; SSED: Summary of Safety and Effectiveness Data.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Population key: 1. Intended use population unclear; 2. Study population is unclear; 3. Study population not representative of intended use; 4. Enrolled populations do not reflect relevant diversity; 5. Other.

<sup>b</sup> Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest (e.g., proposed as an adjunct but not tested as such); 5. Other.

<sup>c</sup> Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively; 5. Other.

<sup>d</sup> Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. Incomplete reporting of harms; 4. Not establish and validated measurements; 5. Clinically significant difference not prespecified; 6. Clinically significant difference not supported; 7. Other.

<sup>e</sup> Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms; 3. Other.

**Table 18. Study Design and Conduct Limitations**

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Knops et al (2023) <sup>86</sup> ; FDA SSED (2023); PMA P150035 <sup>30</sup> .	1. Participants not randomized; single cohort study described.	1-3. Blinding and outcome assessment not described.				

FDA: Food and Drug Administration; PMA: premarket approval; SSED: Summary of Safety and Effectiveness Data.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias; 5. Other.

<sup>b</sup> Blinding key: 1. Participants or study staff not blinded; 2. Outcome assessors not blinded; 3. Outcome assessed by treating physician; 4. Other.

<sup>c</sup> Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication; 4. Other.

<sup>d</sup> Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials); 7. Other.

<sup>e</sup> Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference; 4. Other.

<sup>f</sup> Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated; 5. Other.

## Section Summary: Dual-Chamber Pacing for Individuals Who Are Medically Eligible for a Conventional Pacing System

The evidence for the use of the Aveir DR leadless pacemaker system consists of a pivotal prospective single cohort study. Results from 3 months and 6 months of the pivotal study reported freedom from complications in 90.3% and 89.1% of individuals, respectively, and adequate atrial capture threshold and sensing amplitude in 90.2% and 90.8% of individuals, respectively. Acute and long-term events will be captured in a post approval study through 9 years.

## Dual-Chamber Pacing for Individuals Who are Medically Ineligible for a Conventional Pacing System

### **Clinical Context and Therapy Purpose**

The purpose of dual-chamber pacing systems in individuals with a class I or II guidelines-based indication for implantation of a dual-chamber pacemaker is to provide a treatment option that is an alternative to or an improvement on conventional pacing systems.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with a class I or II guidelines-based indication for implantation of a dual-chamber pacemaker who are medically ineligible for a conventional pacing system.

#### ***Interventions***

The therapy being considered is a dual-chamber pacing system (e.g., Aveir).

#### ***Comparators***

The following therapy and practice are currently being used to make decisions about managing individuals ineligible for a conventional pacemaker: medical management and/or surgical epicardial dual-chamber pacemaker.

#### ***Outcomes***

The general outcomes of interest are treatment-related mortality and morbidity. Specifically, the short-term outcomes include acute complication-free survival rate, the electrical performance of the device, including the pacing capture threshold, and adverse events, including procedural and postprocedural complications. Long-term outcomes include chronic complication-free survival rate, the electrical performance of the device, including pacing impedance and pacing thresholds, and chronic complications, including any system explant, replacement (with and without system explant), and repositions. Further, analysis of summary statistics regarding battery length is important. To assess short-term safety, the first 30 days postimplant is generally considered appropriate because most device and procedural complications occur within this time frame. To assess long-term efficacy and safety as well as issues related to device end-of-life, a follow-up to 9 to 12 years postimplant with an adequate sample size are required to characterize device durability and complications with sufficient certainty.

### **Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies on the currently marketed version of the technology were sought.
- Studies with duplicative or overlapping populations were excluded.

No studies that exclusively enrolled individuals who were medically ineligible to receive a conventional pacing system were identified.

### **Section Summary: Dual-Chamber Pacing for Individuals Who Are Medically Ineligible for a Conventional Pacing System**

No studies that exclusively enrolled individuals who were medically ineligible for a conventional pacing system were identified.

## Summary of Evidence

For individuals with a guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system who receive a single-chamber transcatheter pacing system, the evidence includes a systematic review, pivotal prospective cohort studies, a postapproval prospective cohort study, a Medicare registry, and a retrospective US Food and Drug Administration (FDA) database analysis. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Results at 6 months and 1 year for the Micra pivotal study reported high procedural success (>99%) and device effectiveness (pacing capture threshold met in 98% of patients). Most of the system- or procedure-related complications occurred within 30 days. At 1 year, the incidence of major complications did not increase substantially from 6 months (3.5% at 6 months vs. 4% at 1 year). Results of the Micra postapproval study were consistent with the pivotal study and showed a lower incidence of major complications up to 30 days postimplantation as well as 1 year (1.5% and 2.7%, respectively). In both studies, the point estimates of major complications were lower than the pooled estimates from 6 studies of conventional pacemakers used as a historical comparator. While Micra device eliminates lead- and surgical pocket-related complications, its use can result in potentially more serious complications related to implantation and release of the device (traumatic cardiac injury) and less serious complications related to the femoral access site (groin hematomas, access site bleeding). Initial data from a Medicare registry found a significantly higher rate of pericardial effusion and/or perforation within 30 days in patients with the leadless Micra pacemaker compared to patients who received a transvenous device; however, overall 6-month complication rates were significantly lower in the Micra group in the adjusted analysis ( $p=.02$ ). In a real-world study of Medicare patients, the Micra device was associated with a 41% lower rate of reinterventions and a 32% lower rate of chronic complications compared with transvenous pacing, with no significant difference in adjusted all-cause mortality at 3 years despite the higher comorbidity index for patients implanted with a Micra device. However, patients receiving the Micra device experienced significantly more other complications, driven by higher rates of pericarditis. No significant differences were noted in the composite endpoint of time to heart failure hospitalization or death for the full cohort ( $p=.28$ ) or the subgroup without a history of heart failure ( $p=.98$ ). It is also unclear whether all patients were considered medically eligible for a conventional pacing system. A single-arm study of the Micra AV device reported that 85.2% of individuals with complete atrioventricular (AV) block and normal sinus rhythm successfully achieved a >70% resting AV synchrony (AVS) rate at 1 month postimplant and that AVS rates could be further enhanced with additional device programming. However, clinically meaningful rates of AVS are unknown. Longer-term device characterization is planned in the Micra AV Post-Approval Registry through 3 years. The Aveir pivotal prospective cohort study primary safety and efficacy outcomes at 6 weeks exceeded performance goals for complication-free rate and composite success rate (96.0% and 95.9%, respectively). Results at 6 months were similar and at 1 year were 93.2% and 91.5%, respectively. Incidence of major complications at 1 year was 6.7% compared to 4.0% in the Micra pivotal trial. The 2-year survival estimate of 85.3% is based on Phase 1 performance with the predecessor Nanostim device. Considerable uncertainties and unknowns remain in terms of the durability of the devices and device end-of-life issues. Early and limited experience with the Micra device has suggested that retrieval of these devices is unlikely because in due course, the device will be encapsulated. There are limited data on device-device interactions (both electrical and mechanical), which may occur when there is a deactivated Micra device alongside another leadless pacemaker or when a leadless pacemaker and transvenous device are both present. Although the Aveir device is specifically designed to be retrieved when therapy needs evolve or the device needs to be replaced, limited data are available on retrieval outcomes. While the current evidence is encouraging, overall benefit with the broad use of FDA-approved single-chamber transcatheter pacing systems compared with conventional pacemakers has not been shown. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a single-chamber transcatheter pacing system, the evidence includes subgroup analysis of a pivotal prospective cohort study and a

postapproval prospective cohort study for the Micra device. It is unclear whether the Aveir pivotal study enrolled patients medically ineligible for a conventional pacing system. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Information on the outcomes in the subgroup of patients from the postapproval study showed that the Micra device was successfully implanted in 98% to 99% of cases, and safety outcomes were similar to the original cohort. Even though the evidence is limited and long-term effectiveness and safety are unknown, the short-term benefits may outweigh the risks because the complex trade-off of adverse events for these devices needs to be assessed in the context of the life-saving potential of pacing systems for patients ineligible for conventional pacing systems. There are little data available regarding outcomes associated with other alternatives to conventional pacemaker systems such as epicardial leads or transiliac placement. Epicardial leads are most relevant for the patient who is already going to have a thoracotomy for treatment of their underlying condition (e.g., congenital heart disease). Epicardial leads are associated with a longer intensive care unit stay, more blood loss, and longer ventilation times compared to conventional pacemaker systems. The evidence for transiliac placement is limited to small case series and the incidence of atrial lead dislodgement using this approach in the literature ranged from 7% to 21%. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a dual-chamber pacing system who are medically eligible for a conventional pacing system who receive a dual-chamber leadless pacing system, the evidence includes a pivotal prospective single cohort study. Relevant outcomes are freedom from complications and adequate atrial capture threshold and sensing amplitude. Results from 3 months and 6 months or the pivotal study reported freedom from complications in 90.3% and 89.1% of individuals, respectively, and adequate atrial capture threshold and sensing amplitude in 90.2% and 90.8% of individuals, respectively. Acute and long-term events will be captured in a post approval study through 9 years. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a guidelines-based indication for a dual-chamber pacing system who are medically ineligible for a conventional pacing system who receive a dual-chamber leadless pacing system, no evidence was identified that exclusively enrolled individuals who were medically ineligible for a conventional pacing system. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

### **Supplemental Information**

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

### **Clinical Input from Physician Specialty Societies and Academic Medical Centers**

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

### **2023 Input**

Clinical input was sought to help determine whether the use of an Aveir or Micra AV transcatheter pacing system for an individual with a guidelines-based indication for a ventricular pacing system would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice depending on individual medical eligibility for a conventional pacing system. In response to requests, clinical input was received from 2 respondents, including 1 specialty society-level response including physicians with academic medical center affiliation and 1 physician-level response with academic affiliation identified through a specialty society.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a Micra AV or Aveir transcatheter pacing system, clinical input supports this use provides a clinically meaningful improvement in net health outcomes and indicates this use is consistent with generally accepted medical practice in a subgroup of appropriately selected patients when both conditions below are met:

- The patient has significant bradycardia and:
  - Normal sinus rhythm with rare episodes of 2° or 3° atrioventricular (AV) block or sinus arrest and severe physical disability or short expected lifespan; OR
  - Chronic atrial fibrillation.
- The patient has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:
  - History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection;
  - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins, or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis;
  - Presence of a bioprosthetic tricuspid valve.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system who receive a Micra AV or Aveir transcatheter pacing system, clinical input indicates this use is consistent with generally accepted medical practice but reports mixed support that this use provides a clinically meaningful improvement in net health outcomes.

Further details from clinical input are included in the Appendix.

### 2019 Input

Clinical input was sought to help determine whether the use of leadless cardiac pacemakers for individuals with a guidelines-based indication for a ventricular pacing system would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input was received from 2 respondents, including 1 specialty society-level response and 1 physician-level response identified through specialty societies including physicians with academic medical center affiliations.

For individuals with a guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system who receive a Micra transcatheter pacing system, clinical input supports this use provides a clinically meaningful improvement in net health outcomes and indicates this use is consistent with generally accepted medical practice in a subgroup of appropriately selected patients when both conditions below are met:

- The patient has symptomatic paroxysmal or permanent high-grade arteriovenous block or symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses).
- The patient has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:
  - History of an endovascular or CIED infection or who are very high-risk for infection
  - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis
  - Presence of a bioprosthetic tricuspid valve

Further details from clinical input are included in the Appendix.

### Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

#### American College of Cardiology Foundation et al

In 2012, The American College of Cardiology Foundation (ACCF), American Heart Association (AHA), and the Heart Rhythm Society (HRS) issued a focused update of the ACCF/AHA/HRS 2008 guidelines for device-based therapy of cardiac rhythm abnormalities.<sup>87</sup> These guidelines included recommendations regarding permanent pacemaker implantation in individuals with class I or II indications.

#### Heart Rhythm Society

In 2020, HRS, along with the International Society for Cardiovascular Infectious Diseases (ISCVID) and several other Asian, European and Latin American societies, endorsed the European Heart Rhythm Association (EHRA) international consensus document on how to prevent, diagnose, and treat cardiac implantable electronic device infections.<sup>88</sup> The consensus states that for patients at high risk of device-related infections, avoiding a transvenous system and implanting an epicardial system may be preferential. It makes the following statements regarding leadless pacemakers:

- 'There is hope that 'leadless' pacemakers will be less prone to infection and can be used in a similar manner [as epicardial systems] in high-risk patients.'
- 'In selected high-risk patients, the risk of infection with leadless pacemakers appears low. The device also seems safe and feasible in patients with pre-existing [cardiovascular implantable electronic device] infection and after extraction of infected leads.'

#### National Institute for Health and Care Excellence

In 2018, the NICE issued evidence-based recommendations on leadless cardiac pacemaker implantation for adults with bradyarrhythmias.<sup>89</sup> The guidance states that the evidence "on the safety of leadless cardiac pacemaker implantation for bradyarrhythmias shows that there are serious but well-recognised complications. The evidence on efficacy is inadequate in quantity and quality:

- For people who can have conventional cardiac pacemaker implantation, leadless pacemakers should only be used in the context of research;
- For people in whom a conventional cardiac pacemaker implantation is contraindicated following a careful risk assessment by a multidisciplinary team, leadless cardiac pacemakers should only be used with special arrangements for clinical governance, consent and audit or research."

The guidance is awaiting development as of April 2023 with expected publication in June 2024.

#### U.S. Preventive Services Task Force Recommendations

Not applicable.

#### Medicare National Coverage

The Centers for Medicare & Medicaid (CMS) cover leadless pacemakers under coverage with evidence development criteria when procedures are performed in prospective longitudinal studies approved by the U.S. Food and Drug Administration (FDA) using "leadless pacemakers...in accordance with the FDA approved label for devices that have either:

- An associated ongoing FDA approved post-approval study; or
- Completed an FDA post-approval study.

Each study must be approved by CMS and as a fully-described, written part of its protocol, must address the following research questions:

- What are the peri-procedural and post-procedural complications of leadless pacemakers?
- What are the long term outcomes of leadless pacemakers?
- What are the effects of patient characteristics (age, gender, comorbidities) on the use and health effects of leadless pacemakers?"<sup>90</sup>.

The following 6 studies are currently approved by CMS:<sup>91</sup>.

1. Aveir AR Coverage With Evidence Development (CED) Study (ARRIVE) (NCT06100770); CMS approval date: 01/18/24;
2. Aveir DR CED Study (NCT05932602); CMS approval date: 10/31/23;
3. Aveir VR Coverage With Evidence Development Post-Approval Study (NCT05336877); CMS approval date: 06/21/22;
4. Effectiveness of the EMPOWER™ Modular Pacing System and EMBLEM™ Subcutaneous ICD to Communicate Antitachycardia Pacing (NCT04798768); CMS approval date: 01/20/22;
5. The LEADLESS II IDE Study (Phase II): A Safety and Effectiveness Trial for a Leadless Pacemaker System (NCT04559945); CMS approval date: 03/16/21;
6. Longitudinal Coverage with Evidence Development Study on Micra AV Leadless Pacemakers (Micra AV CED) (NCT04235491); CMS approval date: 02/05/20;
7. The Micra CED Study (NCT03039712); CMS approval date: 03/09/17; and
8. Micra Transcatheter Pacing System Post-Approval Registry (NCT02536118); CMS approval date: 02/09/17.

See Table 19 for additional details.

### Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 19.

**Table 19. Summary of Key Trials**

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
NCT06100770 <sup>a,b</sup>	Aveir AR Coverage With Evidence Development (CED) Study	586	Jan 2031 (ongoing)
NCT05932602 <sup>a,b</sup>	The AVEIR DR Coverage With Evidence Development (DRIVE) Study	2812	Oct 2025 (ongoing)
NCT05935007 <sup>a</sup>	Aveir Dual-Chamber Leadless Pacemaker Real-World Evidence Post-Approval Study	1805	Jan 2030 (ongoing)
NCT05856799	Danish Randomized Trial on VDD Leadless Atrial Tracking With Micra™ AV Transcatheter Pacing System vs Transvenous DDD Pacing in Elderly Patients With AV-block	80	Aug 2025 (ongoing)
NCT05817695	Effect of Different Pacing Sites on Cardiac Synchronization and Tricuspid Regurgitation After Leadless Pacemaker Implantation	40	May 2023 (ongoing)
NCT04559945 <sup>a,b</sup>	The LEADLESS II IDE Study (Phase II): A Safety and Effectiveness Trial for a Leadless Pacemaker System	326	Aug 2023 (ongoing)
NCT05528029	International Leadless Pacemaker Registry (i-LEAPER)	2000	Dec 2024 (recruiting)
NCT04253184 <sup>a</sup>	Micra AV Transcatheter Pacing System Post-Approval Registry (Micra AV PAS)	802	Apr 2025 (ongoing)
NCT05498376	The Leadless AV Versus DDD Pacing Study: A Randomized Controlled Single-center Trial on Leadless Versus Conventional Cardiac Dual-chamber Pacing (LEAVE DDD)	100	Feb 2026 (recruiting)
NCT04235491 <sup>a,b</sup>	Longitudinal Coverage With Evidence Development Study on Micra AV Leadless Pacemakers (Micra AV CED)	37000	Jun 2027 (ongoing)
NCT04051814	A Retrospective Trial to Evaluate the Micra Pacemaker	500	May 2025 (recruiting)
NCT03039712 <sup>a,b</sup>	Longitudinal Coverage With Evidence Development Study on Micra Leadless Pacemakers (Micra CED)	37000	Jun 2027 (ongoing)

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT04926792	Taiwan Registry for Leadless Pacemaker	300	Jun 2025 (not yet recruiting)
NCT05252702 <sup>a</sup>	Aveir Dual-Chamber Leadless i2i IDE Study	550	Nov 2025 (recruiting)
NCT02536118 <sup>a,b</sup>	Micra Transcatheter Pacing System Post-Approval Registry	3100	Aug 2026 (ongoing)
NCT05336877 <sup>a,b</sup>	Aveir Single-Chamber Leadless Pacemaker Coverage With Evidence Development (ACED) Post-Approval Study	8744	Jan 2028 (recruiting)
NCT04798768 <sup>a,b</sup>	Effectiveness of the EMPOWER™ Modular Pacing System and EMBLEM™ Subcutaneous ICD to Communicate Antitachycardia Pacing (MODULAR ATP)	300	Dec 2030 (recruiting)

NCT: national clinical trial.

<sup>a</sup> Denotes industry-sponsored or cosponsored trial.

<sup>b</sup> Denotes CMS-approved study.

## Appendix 1

### 2023 Clinical Input

#### Objective

Clinical input was sought to help determine whether the use of the Aveir or Micra AV transcatheter pacing systems for an individual with a guidelines-based indication for a ventricular pacing system would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice depending on individual medical eligibility for a conventional pacing system.

#### Respondents

Clinical input was provided by the following specialty societies and physician members identified by a specialty society or clinical health system:

- Heart Rhythm Society (HRS)
- Ijeoma A. Ekeruo, MD, Cardiac Electrophysiology, University of Texas Health Sciences Center at Houston, identified by the American College of Cardiology (ACC)

\* Indicates that no response was provided regarding conflicts of interest related to the topic where clinical input is being sought.

\*\* Indicates that conflicts of interest related to the topic where clinical input is being sought were identified by this respondent (see Appendix).

Clinical input provided by the specialty society at an aggregate level is attributed to the specialty society. Clinical input provided by a physician member designated by a specialty society or health system is attributed to the individual physician and is not a statement from the specialty society or health system. Specialty society and physician respondents participating in the Evidence Street® clinical input process provide review, input, and feedback on topics being evaluated by Evidence Street. However, participation in the clinical input process by a specialty society and/or physician member designated by a specialty society or health system does not imply an endorsement or explicit agreement with the Evidence Opinion published by BCBSA or any Blue Plan.

#### Clinical Input Responses

			Confidence Level That Clinical Use Expected to Provide Clinically Meaningful Improvement in Net Health Outcome										Confidence Level that Clinical Use is Consistent with Generally Accepted Medical Practice											
			NO					YES					NO					YES						
Clinical Indication	Respondent	Identified by	Yes or No	5	4	3	2	1	1	2	3	4	5	Yes or No	5	4	3	2	1	1	2	3	4	5
Use of an Aveir transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <b>eligible</b> for a conventional pacing system	HRS		YES											YES										
	Dr. Ekeruo	ACC	NO											YES										
Use of an Aveir transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <b>ineligible</b> for a conventional pacing system	HRS		YES											YES										
	Dr. Ekeruo	ACC	YES											YES										
Use of a Micra AV transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <b>eligible</b> for a conventional pacing system	HRS		YES											YES										
	Dr. Ekeruo	ACC	NO											YES										
Use of a Micra AV transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <b>ineligible</b> for a conventional pacing system	HRS		YES											YES										
	Dr. Ekeruo	ACC	YES											YES										

ACC: American College of Cardiology; HRS: Heart Rhythm Society.

## Respondent Profile

Specialty Society					
#	Name of Organization		Clinical Specialty		
1	Heart Rhythm Society		Electrophysiology		
Physician					
#	Name	Degree	Institutional Affiliation	Clinical Specialty	Board Certification and Fellowship Training
Identified by American College of Cardiology					
2	Ijeoma A. Ekeruo	MD	University of Texas	Cardiac Electrophysiology	Cardiac Electrophysiology and Cardiology

## Respondent Conflict of Interest Disclosure

#	1) Research support related to the topic where clinical input is being sought		2) Positions, paid or unpaid, related to the topic where clinical input is being sought		3) Reportable, more than \$1,000, healthcare–related assets or sources of income for myself, my spouse, or my dependent children related to the topic where clinical input is being sought		4) Reportable, more than \$350, gifts or travel reimbursements for myself, my spouse, or my dependent children related to the topic where clinical input is being sought	
	YES/NO	Explanation	YES/NO	Explanation	YES/NO	Explanation	YES/NO	Explanation
1	NR	See below	NR	See below	NR	See below	NR	See below
2	No		No		No		No	

### # Conflict of Interest Policy Statement

1	The Heart Rhythm Society's Health Policy and Regulatory Affairs Committee provided input into the response. HRS has an Ethics Committee which has established procedures for monitoring disclosures and ensuring compliance with the Society's Code of Ethics and Professional Standards. HRS requires all individuals engaged in HRS-related activities to disclose and manage personal, professional, financial, and non-financial relationships while engaged in Society's activities.
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Individual physician respondents answered at individual level. Specialty Society respondents provided aggregate information that may be relevant to the group of clinicians who provided input to the Society-level response. NR = not reported

## Detailed Responses

### Question 1:

We are seeking your opinion on whether using an Aveir transcatheter pacing system for each of the indications below provides a clinically meaningful improvement in net health outcome. Please respond based on the evidence and your clinical experience. Please address these points in your response:

- Relevant clinical scenarios (e.g., a chain of evidence) where the technology is expected to provide a clinically meaningful improvement in net health outcome;
- Any relevant patient inclusion/exclusion criteria or clinical context important to consider in identifying individuals for this indication; and
- Supporting evidence from the authoritative scientific literature (please include PMID).
  - Use of an Aveir transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who is medically eligible for a conventional pacing system

#	Rationale
1	<p>The Heart Rhythm Society (HRS) endorses that Aveir and other leadless pacemaker (LP) systems provide incremental health benefit in select patients who are otherwise eligible for conventional pacing (CP) systems.</p> <p>LP systems can mitigate or eliminate complications and sequela that are specific to CP systems. CP implant complications that are eliminated with LPs include pneumothorax, surgical pocket hematoma and upper extremity deep venous thrombosis. These complications then require additional interventions such as reoperations, chest tube placement, thrombolysis, or anticoagulation that have their own risks of complications. Intermediate or long-term sequela of chronically implanted CP include pectoral pocket or lead infection, chronic CP pocket pain due to device migration or pre-erosion or erosion of the CP generator through the skin. Device infection is an important source of morbidity and mortality from both the infection or lead extraction. Since 80% of device infections involve the pacemaker generator pocket, LPs would eliminate CP pectoral pocket infections.</p> <p>Patients with comorbidities are at higher risk when CP complications occur. Patients at risk for poor wound healing from radiation, chronic cachexia, burns or autoimmune disease such as scleroderma or would benefit from LP as an alternative to the CP implant procedure. Patients with severe lung disease or chronic ventilation are at increased risk when pneumothorax occurs. Patients undergoing chronic hemodialysis have ongoing challenges with vascular access, bleeding risk and infection when CPs are placed ipsilateral to upper extremity AV fistulas. Some patients have illnesses where preserving upper extremity vascular access sites is critical for future therapies such as infusions. Patients who require continuous anticoagulation due to mechanical heart valves or left ventricular assist devices (LVADs) are at risk if anticoagulation is suspended to manage pocket hematomas. Patients who have upper body central venous stenosis are at risk for complete occlusion with chronically indwelling CP leads, so LPs would eliminate this risk. These patients may need vascular interventions that would compromise the CP lead or require its removal. A CP ventricular lead implanted interacts with the tricuspid valve with every heartbeat 100,000 times per day. There is increasing awareness that years of this can contribute to tricuspid valve dysfunction that require tricuspid valve repair or replacement. For patients that have had these interventions, clinicians have reasonable concern that placement of CP leads could adversely affect the function of the repaired or replaced tricuspid valve.</p> <p>References            Armaganijan, L. V., et al. (2012). "Are elderly patients at increased risk of complications following pacemaker implantation? A meta-analysis of randomized trials." <i>Pacing and clinical electrophysiology</i> 35(2): 131-134            Beyene, R. T., et al. (2020). "The effect of comorbidities on wound healing." <i>Surgical Clinics</i> 100(4): 695-705            Cho, M. S., et al. (2019). "Incidence and predictors of moderate to severe tricuspid regurgitation after dual-chamber pacemaker implantation." <i>Pacing and clinical electrophysiology</i> 42(1): 85-92.            Link, M. S., et al. (1998). "Complications of dual chamber pacemaker implantation in the elderly." <i>Journal of interventional cardiac electrophysiology</i> 2(2): 175.</p>
2	<p>There are cases in which a leadless pacemaker would be placed in a patient that can otherwise receive a transvenous pacemaker. The major limitation to the leadless pacemaker not being standard of care in these patients seems to be limited data on long term effects of pacer placement, and lack of clarity on what to do with battery depletion. Though this is theoretically addressed in the Aveir transcatheter system, there is still no long-term data to prove efficacy.</p> <p>Literature available (PMID: 32763431, 34319383) report a decrease in major complications post implant, though an increase in pericardial effusion following implant, with reduction occurring mainly with lack of pneumothorax, pocket hematoma and pocket infection in the acute period. Interestingly, there is also no</p>

#	Rationale
	significant difference in mortality with patients who received an intravenous device when followed for up to 36 months post implant.
	With this in mind, it is reasonable to conclude that placement of a leadless device in a patient who is otherwise a candidate for a transvenous single lead device would be acceptable, with consideration of the patient's age and need for generator change as a result of battery depletion.
	<ul style="list-style-type: none"> <li>○ Use of an Aveir transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who is medically <u>ineligible</u> for a conventional pacing system</li> </ul>

#	Rationale
1	HRS strongly supports the use of Aveir and other LP systems that meet ventricular pacing indications who are medically ineligible for CP systems. These would include, but not be limited to, obstructed vascular access, inability to place the CP generator in an appropriate surgical plane, recurring infections, or clinical scenarios where therapies or surgery would disrupt, damage, entrap, or subject the CP system components. Before LP availability, the only alternative for these patients would be a thoracotomy-based epicardial pacing system or off-label CP implant techniques such as transiliac or transhepatic approaches. LPs offer a less invasive alternative with established long-term benefits. Patients could also be deemed ineligible if they are unable to comply with CP postoperative instructions due to mental health or developmental challenges.
2	The development of the leadless pacing system was borne out of necessity, in cases where patients did not have upper extremity venous access to the right heart (either as a result of venous occlusion, or congenital malformation), or in patients with recurrent infections.
	There are no trials comparing patients ineligible for a conventional pacing system who receive leadless pacemakers to those with transiliac or epicardial devices for a completely pacing indication. When compared to the alternative, placement of a leadless pacing system in this group of patients should be deemed necessary, as the alternative would confer a higher degree of mortality and morbidity in this population.

### Question 2:

Also please comment on whether or not the patient selection criteria (as adapted from device instructions for use) below are reasonable to define the population for use of an Aveir transcatheter pacing system among individuals who are medically ineligible for a conventional pacing system.

- The patient has significant bradycardia and:
  - Normal sinus rhythm with only rare episodes of 2° or 3° atrioventricular (AV) block or sinus arrest and severe physical disability or short expected lifespan; OR
  - Chronic atrial fibrillation.
- The patient has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:
  - History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection;
  - Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins, or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis;
  - Presence of a bioprosthetic tricuspid valve.

#	YES/NO	Rationale
1	YES	<p>The Society believes that the Aveir system is a suitable alternative in clinical situations where the clinician believes that CP placement or its long-term sequela places the patient at undue risk. Many of these conditions (infection, vascular access, dialysis, bioprosthetic tricuspid valve) were reviewed in the previous section.</p> <p>Some patients have infrequent episodes of atrioventricular block with severe symptoms and rarely need intervention from a pacemaker. LPs can provide this therapy without the long-term</p>

#	YES/NO	Rationale
		<p>risk of chronically implanted CP systems. Aveir is designed to be removed and the LP can be replaced with a CP or other device if needed later in life. Patients who are frail or elderly are at increased risk from CP complications, so LP could be used as an alternative to mitigate risks that are specific to CPs.</p> <p>The Society also believes it is reasonable to use Aveir and other LPs for intermediate (&gt;48 hours) or longer-term temporary pacing when a patient's clinical status precludes them from receiving a CP or other device, such as with infection or after cardiac procedures. External temporary pacing systems are currently used for this, and the patient is unable to leave their bed or the ICU until it is removed. These external systems are vulnerable to dislodgement and can lose their ability to pace after several days. Aveir's ability to be implanted then later removed offers would allow to ambulate and be housed in less acute settings or even discharged, allowing limited healthcare resources available for other patients.</p> <p>References</p> <p>Sohail, M. R., et al. (2007). "Risk factor analysis of permanent pacemaker infection." <i>Clinical Infectious Diseases</i> 45(2): 166-173</p> <p>Beccarino, N. J., et al. (2023). "Concomitant leadless pacing in pacemaker-dependent patients undergoing transvenous lead extraction for active infection: Mid-term follow-up." <i>Heart Rhythm</i></p> <p>Gonzales, H., et al. (2019). "Comparison of leadless pacing and temporary externalized pacing following cardiac implanted device extraction." <i>The Journal of Innovations in Cardiac Rhythm Management</i> 10(12): 3930</p>
2	YES	NR
NR: no response.		

**Question 3:**

Please describe how severe physical disability is measured and defined for the Aveir intended use population. Please describe whether this definition is applicable across device types (i.e., Micra VR, Micra AV). If not, please clarify important differences.

#	Rationale
1	Severe physical disability encompasses a variety of conditions where CP placement would confer undue acute or long-term risk. This could be inability to comply with postoperative wound care instructions due to physical, mental health, or developmental challenges. Severe disability due to end stage heart, lung, neurologic or skeletal diseases could raise the risk of CP implants. Patients with severe disabilities would benefit from an LP implant procedure that does not involve surgery and its associated postoperative discomfort that could further compromise their limited ability to meet their activities of daily living.
2	It is hard for this physician to think of significant physical disability that would preclude placement of a transvenous device. Maybe severe scoliosis or upper extremity spasm limiting access to the subclavian or axillary vein, and would also increase the possibility of lead dislodgement or fracture. In this case, this definition would be applicable across all device types.

**Question 4:**

Please comment on how the clinical use of the Aveir system differs from the Micra VR and AV systems. Are these devices used in the same subset of patients? What clinical considerations drive the choice of transcatheter pacing system?

#	Rationale
1	<p>All LPs such as Aveir can be appropriately used in patients that meet guideline-based ventricular pacing indications. Aveir and Micra VR provide rate responsive ventricular pacing (VVIR). In addition to VVIR pacing the Micra AV can sense atrial electrical signals that trigger and synchronize ventricular pacing (VDDR). This atrioventricular (AV) synchrony allows the Micra AV to be used in patients with chronic AV block that do not need atrial pacing. Aveir and Micra VR are only indicated where AV block occurs rarely. The distinguishing feature of Aveir is the FDA approved tools and technique for device removal.</p> <p>Aveir devices have been removed as long as 9 years after implant. This would be an attractive option if removal of the device is needed or desired. The manufacturer (Abbott) claims that the Aveir has better</p>

#	Rationale
	<p>longevity across a wider range of pacing outputs. This would be advantageous since pacing thresholds tend to increase over time.</p> <p>Reference Neužil, P., et al. (2023). "Retrieval and replacement of a helix-fixation leadless pacemaker at 9 years post-implant." HeartRhythm Case Reports</p>
2	<p>The clinical use of the Aveir system and the Micra VR system would be similar.</p> <p>The Micra AV system differs in that it has an added benefit of allowing for AV synchrony, and so can be used in cases where pacemaker syndrome would be a consideration, or where synchrony would be preferred.</p>

#### Question 5:

We are seeking your opinion on whether using a Micra AV transcatheter pacing system for each of the indications below provides a clinically meaningful improvement in net health outcome. Please respond based on the evidence and your clinical experience. Please address these points in your response:

- Relevant clinical scenarios (e.g., a chain of evidence) where the technology is expected to provide a clinically meaningful improvement in net health outcome;
- Any relevant patient inclusion/exclusion criteria or clinical context important to consider in identifying individuals for this indication; and
- Supporting evidence from the authoritative scientific literature (please include PMID).
  - Use of Micra AV transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who is medically eligible for a conventional pacing system

#	Rationale
1	<p>Heart Rhythm Society (HRS) endorses that Micra AV and other leadless pacemaker (LP) systems provide clinically meaningful improvement in net health outcome several scenarios in which patients are medically eligible for conventional pacing (CP) system (i.e. high grade AV block in the presence or absence of atrial fibrillation; symptomatic bradycardia or sinus node dysfunction as an alternative to atrial or dual chamber pacing; patients with adequate sinus rates but AV block who may benefit from AV synchronous ventricular pacing).</p> <ol style="list-style-type: none"> <li>1. Alternative to dual chamber pacing when transvenous pacing system insertion is considered difficult (e.g. venous obstruction prohibiting access) or high risk (e.g. current infection or recently extracted infected system).</li> <li>2. Prevent pocket erosion in patients with inadequate subcutaneous tissue.</li> <li>3. Mitigate risk of chronic vascular occlusion in young patients with rare severe vasovagal mediated syncope.</li> <li>4. Reduce risk of transvenous lead failure associated with mechanical stress related to activity (e.g. hunting, golf).</li> <li>5. Avoid cosmetic scars associated with traditional prepectoral pocket formation.</li> <li>6. There is some evidence that the Micra could be used safely concomitantly with a subcutaneous implantable cardioverter defibrillators.</li> </ol> <p>References: (1) JACC: Clinical Electrophysiology, 3 (2017) 1487-1498. doi:10.1016/j.jacep.2017.04.002; (2) Journal of the American College of Cardiology, 67 (2016) 1865-1866. doi:10.1016/j.jacc.2016.02.039</p>
2	<p>The development of the Micra AV transcatheter pacing system has increased indications for leadless pacemaker placement in patients in need of AV synchrony, particularly patients with second or third degree AV block. The system suffers from the same limitations as its sister device, with longevity limited to &lt;10 years and long term outcomes not available for that reason. Though this device provides AV synchrony, it is not as robust as that provided with a transvenous system, with no ability to provide such at HR &gt;105 bpm, and limited in patients with significant diastolic dysfunction. In patients with need for AV synchrony at higher heart rates, they would be better served with a conventional system.</p> <p>The patients that would benefit from this device remain older patients, with limited activity, in whom device</p>

infection or lead dislodgement remains a significant concern. Otherwise, patients in whom placement of a conventional system would be impossible remain the greatest beneficiaries of this technology.

See PMID 33179814, 31709982

- Use of Micra AV transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who is medically ineligible for a conventional pacing system

#### # Rationale

1 HRS supports the use of Micra AV and other LP systems as an alternative solution in circumstances when CP systems are not favorable or even feasible. Traditional transvenous pacemakers require the formation of a subcutaneous pocket to house the pulse generator and the insertion of transvenous lead(s). These steps could be limited or not possible in many scenarios including the following:

1. Skin and subcuticular conditions (skin burns, prior radiation)
2. Venous system occlusion (subclavian, SVC syndrome, etc)
3. Persistent left sided SVC or other congenital venous anomalies
4. Presence of central venous catheters
5. Presence of Arterio-Venous fistula for dialysis on the same upper extremity
6. Bioprosthetic tricuspid valve and the desire to avoid any transvalvular lead

These anatomical challenges are more pronounced after extraction of an infected device as the options are limited to the opposite prepectoral side for new system implantation. The inability to perform implantation of a transvenous pacemaker system has traditionally led to trans-iliac or surgical epicardial pacemaker approaches. These approaches require special expertise or necessitate a surgical invasive procedure. Additionally, the long term performance of transiliac leads or epicardial leads is suboptimal.

#### References

1. Cantillon DJ, Exner DV, Badie N, Davis K, Gu NY, Nabutovsky Y, Doshi R. Complications and Health Care Costs Associated With Transvenous Cardiac Pacemakers in a Nationwide Assessment. JACC Clin Electrophysiol. 2017. Nov;3(11):1296-1305. doi: 10.1016/j.jacep.2017.05.007. Epub 2017 Aug 30. PubMed PMID: 29759627.
2. Kirkfeldt RE, Johansen JB, Nohr EA, Jørgensen OD, Nielsen JC. Complications after cardiac implantable electronic device implantations: an analysis of a complete, nationwide cohort in Denmark. Eur Heart J. 2014 May;35(18):1186-94. doi: 10.1093/eurheartj/ehu511. Epub 2013 Dec 17. PubMed PMID: 24347317; PubMed Central PMCID: PMC4012708.
3. Udo EO, Zuithoff NP, van Hemel NM, de Cock CC, Hendriks T, Doevendans PA, Moons KG. Incidence and predictors of short - and long-term complications in pacemaker therapy: the FOLLOWPACE study. Heart Rhythm. 2012 May;9(5):728-35. doi: 10.1016/j.hrthm.2011.12.014. Epub 2011 Dec 17. PubMed PMID: 22182495

2 Like the VR systems available, placement of a Micra AV in a patient that is ineligible for transvenous system placement would be an improvement on present alternatives (epicardial pacing, transiliac pacing [with generator in the abdomen]). There is significant concern for increase in lead threshold in the forer, and lower extremity pain in the latter to confer a clear advantage for the leadless system.

See PMID 518184, 22192754

#### Question 6:

Also please comment on whether or not the patient selection criteria (as adapted from device instructions for use) below are reasonable to define the population for use of an Micra AV transcatheter pacing system among individuals who are medically ineligible for a conventional pacing system.

- The patient has significant bradycardia and:
  - Normal sinus rhythm with only rare episodes of 2° or 3° AV block or sinus arrest and severe physical disability or short expected lifespan; OR
  - Chronic atrial fibrillation.
- The patient has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following:

- History of an endovascular or CIED infection or who are at high risk for infection;
- Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins, or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis;
- Presence of a bioprosthetic tricuspid valve.

#	YES/NO	Rationale
1	YES	<p>HRS agrees the patient selection criteria are reasonable. Criterion 1: Patients with rare episodes of AV block or sinus arrest will rarely require pacing intervention. LPs can provide this therapy with less risk in patients with severe physical disability or short expected lifespan including potential transvenous lead infection or failure. If a patient has high degree AV block frequently, Micra AV will result in the preservation of AV synchrony.</p> <p>Criterion 2: Patients with significant contraindication precluding CP system including endovascular or CIED infection, limited access for transvenous pacing, and presence of bioprosthetic tricuspid valve. LP systems have low risk of infection (1). Alternative external temporary pacing systems are vulnerable to dislodgment and loss of capture. LP systems can be inserted alternatively to occluded axillary venous systems.</p> <p>Reference  1. El-Chami MF, Bonner M, Holbrook R, Stromberg K, Mayotte J, Molan A, Sohail MR, Epstein LM. Leadless pacemakers reduce risk of device-related infection: Review of the potential mechanisms. <i>Heart Rhythm</i>. 2020 Aug;17(8):1393-1397. doi: 10.1016/j.hrthm.2020.03.019. Epub 2020 Apr 2. PMID: 32247833.</p>
2	YES	NR

NR: no response.

### Question 7:

Please comment on how the clinical use of the Micra VR system (Model MC1VR01) differs from the Micra AV system (Model MC1AVR1). Can these devices be used in the same subset of patients? What clinical considerations drive the choice of transcatheter pacing system?

#	Rationale
1	<p>Micra VR and Micra AV systems can be used in the same subset of patients who require ventricular pacing as described above. Micra AV differs from Micra VR in that it provides AV synchrony in patients with AV block without persistent atrial arrhythmia. AV synchrony results in improved cardiac output, reducing risk of atrial fibrillation, and minimizing incidence of pacemaker syndrome (1).</p> <p>Micra AV has several additional atrial sensing algorithms that detect cardiac movement. Micra AV is able to adjust pacing in the ventricle to coordinate with the atrium enabling AV synchronous pacing to people with atrioventricular block. Optimized programmed AV synchrony has been shown to significantly improve quality of life (2).</p> <p>References  1. Steinwender C, Khelae SK, Garweg C, Chan JYS, Ritter P, Johansen JB, Sagi V, Epstein LM, Piccini JP, Pascual M, Mont L, Sheldon T, Splett V, Stromberg K, Wood N, Chinitz L. Atrioventricular Synchronous Pacing Using a Leadless Ventricular Pacemaker: Results From the MARVEL 2 Study. <i>JACC Clin Electrophysiol</i>. 2020 Jan;6(1):94-106. doi: 10.1016/j.jacep.2019.10.017. Epub 2019 Nov 11. PMID: 31709982.  2. Chinitz LA, El-Chami MF, Sagi V, Garcia H, Hackett FK, Leal M, Whalen P, Henrikson CA, Greenspon AJ, Sheldon T, Stromberg K, Wood N, Fagan DH, Sun Chan JY. Ambulatory atrioventricular synchronous pacing over time using a leadless ventricular pacemaker: Primary results from the AccelAV study. <i>Heart Rhythm</i>. 2023 Jan;20(1):46-54. doi: 10.1016/j.hrthm.2022.08.033. Epub 2022 Sep 6. PMID: 36075532</p>
2	<p>The Micra AV system can be used in all populations indicated for a leadless pacemaker. The Micra VR system is limited to patient population in whom AV synchrony would not be an advantage. So mostly patients with permanent atrial fibrillation or patients with very limited (but significant) pacing needs.</p>

**Question 8:**

Please provide in the box below any additional narrative rationale or comments regarding clinical pathway and/or any relevant scientific citations (including the PMID) supporting your clinical input on this topic.

#	Rationale
1	See above comments
2	The use of a leadless system for pacing might also be considered in elderly patients who have transient pacing needs that are significant in the short term. For example, there are no firm indications for placement of pacemakers post TAVR, anecdotal evidence suggests transient AV block that might resolve in 30 days post procedure, too long for an inpatient stay, but maybe too short for the permanent reminder of a device with a pocket and increased risk of infection. A leadless pacing system would be a fine alternative in this specific subset of patients.

**Question 9:**

Is there any evidence missing from the attached draft review of evidence that demonstrates clinically meaningful improvement in net health outcome?

#	YES/NO	Rationale
1	NO	NR
2	NO	NR

NR: no response.

**2019 Clinical Input****Objective**

In 2019, clinical input was sought to help determine whether the use of leadless cardiac pacemakers for 2 populations including individuals with a guidelines-based indication for a ventricular pacing system who are either medically eligible or medically ineligible for a conventional pacing system would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. Clinical input was also sought to help determine reasonable patient selection criteria.

**Respondents**

Clinical input was provided by the following specialty societies and physician members identified by a specialty society or clinical health system:

- Heart Rhythm Society (HRS)
- Kousik Krishnan, MD, Clinical Cardiac Electrophysiology, Rush University Identified by American College of Cardiology (ACC)\*\*

\* Indicates that no response was provided regarding conflicts of interest related to the topic where clinical input is being sought.

\*\* Indicates that conflicts of interest related to the topic where clinical input is being sought were identified by this respondent (see Appendix).

Clinical input provided by the specialty society at an aggregate level is attributed to the specialty society. Clinical input provided by a physician member designated by a specialty society or health system is attributed to the individual physician and is not a statement from the specialty society or health system. Specialty society and physician respondents participating in the Evidence Street® clinical input process provide a review, input, and feedback on topics being evaluated by Evidence Street. However, participation in the clinical input process by a specialty society and/or physician member designated by a specialty society or health system does not imply an endorsement or explicit agreement with the Evidence Opinion published by BCBSA or any Blue Plan.

## Clinical Input Responses

			Confidence Level That Clinical Use Expected to Provide Clinically Meaningful Improvement in Net Health Outcome										Confidence Level that Clinical Use is Consistent with Generally Accepted Medical Practice											
			NO					YES					NO					YES						
			High	Intermediate	Low	Low	Intermediate	High	High	Intermediate	Low	Low	Intermediate	High	High	Intermediate	Low	Low	Intermediate	High				
Clinical Indication	Respondent	Identified by	Yes or No	5	4	3	2	1	1	2	3	4	5	Yes or No	5	4	3	2	1	1	2	3	4	5
Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <b>eligible</b> for a conventional pacing system	HRS		YES											YES										
	Dr. Krishnan**	ACC	YES											YES										
Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <b>ineligible</b> for a conventional pacing system	HRS		YES											YES										
	Dr. Krishnan**	ACC	YES											YES										

ACC: American College of Cardiology; HRS: Heart Rhythm Society

\* Indicates that no response was provided regarding conflicts of interest related to the topic where clinical input is being sought.

\*\* Indicates that conflicts of interest related to the topic where clinical input is being sought were identified by this respondent (see Appendix).

## Respondent Profile

Specialty Society					
#	Name of Organization			Clinical Specialty	
1	Heart Rhythm Society			Electrophysiology	
#	Name	Degree	Institutional Affiliation	Clinical Specialty	Board Certification and Fellowship Training
Identified by American College of Cardiology					
2	Kousik Krishnan	MD	Rush University	Clinical Cardiac Electrophysiology	Cardiac Electrophysiology and Cardiology

## Respondent Conflict of Interest Disclosure

#	1) Research support related to the topic where clinical input is being sought	2) Positions, paid or unpaid, related to the topic where clinical input is being sought	3) Reportable, more than \$1,000, healthcare-related assets or sources of income for myself, my spouse, or my dependent children related to the topic where clinical input is being sought	4) Reportable, more than \$350, gifts or travel reimbursements for myself, my spouse, or my dependent children related to the topic where clinical input is being sought				
	YES/NO	Explanation	YES/NO	Explanation	YES/NO	Explanation	YES/NO	Explanation
1	No		No		No		No	
2	No		No		Yes	Stocks in Medtronic, as well as Mutual Funds that have Medtronic Holdings. Amount unknown.	No	

Individual physician respondents answered at individual level. Specialty Society respondents provided aggregate information that may be relevant to the group of clinicians who provided input to the Society-level response. NR: not reported

## Detailed Responses

- We are seeking your opinion on whether using Micra transcatheter pacing system for each of the indications below in Questions 1a and 1b provides a clinically meaningful improvement in

net health outcome. Please respond based on the evidence and your clinical experience. Please address these points in your response:

- Relevant clinical scenarios (e.g., a chain of evidence) where the technology is expected to provide a clinically meaningful improvement in net health outcome;
- Any relevant patient inclusion/exclusion criteria or clinical context important to consider in identifying individuals for this indication;
- Supporting evidence from the authoritative scientific literature (please include PMID).
  - Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically eligible for a conventional pacing system

#### # Rationale

- 1 We assert that the use of the Micra can provide clinically meaningful improvement in net health outcome for patients who are eligible for a conventional pacing system in multiple contexts and for multiple reasons. See references in Tables 4 and 5 of the BC/BS ES Draft. Along with the FDA and CMS, we assert that the existing studies establish appropriate safety and efficacy for use in the general population.
  1. While the use of the Micra requires ongoing evaluation, it is no longer considered “investigational” given that it has been approved for use by both the FDA and CMS (albeit with specific requirements for follow-up and ongoing evaluation) and thus should be covered by medical insurance across-the-board when considered medically necessary for standard pacing indications.
  2. Future technology will likely include dual-chamber leadless devices and as such it is important for operators to become facile with this technology. For this same reason, we assert that operators who chose to learn this technique should perform this procedure regularly to improve technique and decrease complications that inevitably are more common in rarely performed procedures.
  3. There is some preliminary evidence that the Micra could be used safely concomitantly with a subcutaneous ICD. (Refs: (1) JACC: Clinical Electrophysiology, 3 (2017) 1487-1498. doi:10.1016/j.jacep.2017.04.002; (2) Journal of the American College of Cardiology, 67 (2016) 1865-1866. doi:10.1016/j.jacc.2016.02.039)
  4. There is a spectrum between “eligible” and “ineligible” and as such this distinction is not black and white (see answer to 1a). For example, patients who have had a replaced tricuspid valve but require a ventricular pacing system may not be absolutely “ineligible” for a transvenous system (e.g., could have a small diameter lead placed across the valve) but would likely benefit from having a Micra placed to avoid long-term interaction with the replaced tricuspid valve – and there will likely never be a study large enough to test this clinical judgement).
  5. Young patients with malignant vasovagal syncope who will require rare ventricular pacing but a life-time of devices may benefit from a single-chamber leadless pacemaker as an initial strategy for pacing to minimize risk for device infection and vascular occlusion.
- 2 Micra is a viable option in these patients but does not have superiority data. The data would support that, in a situation with shared decision making, some patients and physicians may prefer a Micra to conventional pacing. (examples: Patients that are younger and would have longer to develop lead related issues, patients at higher infection risk, patients without sufficient subcutaneous tissue to prevent device erosion, patients where vascular access is or will be challenging). This is not an exhaustive list.

- Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically ineligible for a conventional pacing system

#### # Rationale

- 1
  - MICRA leadless pacemaker, which is now FDA approved, has provided electrophysiologists with alternative solution to offer patients in circumstances when traditional transvenous pacemakers are not favorable or not even feasible. Traditional transvenous pacemakers require the formation of a subcutaneous pocket to house the pulse generator and the insertion of transvenous lead(s) into the venous system, across the tricuspid valve into the cardiac chambers. These steps could be limited or not possible in many scenarios including the following:
    1. Skin and subcuticular conditions (skin burns, prior radiation)
    2. Venous system occlusion (subclavian, SVC syndrome, etc...)
    3. Persistent left sided SVC or other congenital venous anomalies
    4. Presence of central venous catheters

## # Rationale

5. Presence of Arterio-Venous fistula for dialysis on the same upper extremity

6. Bioprosthetic tricuspid valve and the desire to avoid any transvalvular lead

These anatomical challenges are more pronounced after extraction of an infected device as the options are limited to the opposite prepectoral side for new system implantation. The inability of performing an implantation of a transvenous pacemaker system has usually led to trans-iliac or surgical epicardial pacemaker approaches. These approaches require special expertise or necessitate a surgical invasive procedure. Additionally, the long term performance of transiliac leads or epicardial leads is suboptimal.

- Infection is a major complication after CIED implantation and 60% of these infections present with pocket infection. Leadless pacemaker by virtue of the technology does not require pocket and therefore could minimize at least the incidence of pocket infection. This is of particular importance among patients at high risk for infection including those who required prior CIED extraction for infection and patients on hemodialysis. Whether the risk of endovascular infection is lower in leadless pacemaker is yet to be determined.
- Majority of transvenous pacemaker complications are related to lead complications and these often result from mechanical stress on the lead itself. Certain activities like hunting, golfing and some professions represent particular stress on transvenous leads. Leadless pacemaker can provide an alternative for patients who suffer lead fracture or malfunction from mechanical stress or could even be first line option pre-emptively when these stresses are expected.
- When single chamber ventricular pacing is indicated, leadless pacemaker can provide an alternative for cosmetic reasons among certain patients in order to avoid prepectoral pocket formation and its associated scar.

These scenarios are not uncommon and frequently encountered in any electrophysiology practice. Complication rates with leadless pacemakers are less than those with traditional pacemaker system (both historical control and more current large patient cohorts from both Europe and US). More importantly, the complication rates with leadless pacemakers have gone down significantly as operators gained more experience. Therefore, building the experience among certain electrophysiologists in implantation technique for leadless pacemakers is critical. While the technology is limited to single chamber ventricular pacing systems, the field is advancing towards multi chamber leadless pacing systems.

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2 This would be an ideal situation for Micra. All other options are higher in morbidity and mortality (example- surgical pacemaker)

NR: not reported

- Also please comment on whether or not the patient selection criteria below (requiring all 4 criteria below to be met) are reasonable to define the population for Question 1b.
  - The patient has symptomatic paroxysmal or permanent high-grade arteriovenous block or symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses).
  - The patient has any of the following, which precludes implantation of a single-chamber ventricular pacemaker:
    - Need for persistent anticoagulation therapy
    - Persistent severe bleeding tendencies
    - Severe lung disease and positive end-expiratory pressure ventilation that precludes internal jugular and subclavian access
    - Congenitally acquired venous anomalies that preclude transvenous access to the heart

OR

- Presence of any of the following and delay in implantation of a single-chamber ventricular pacemaker could be life-threatening:
  - Persistent or recurrent local infection at implantation site
  - Persistent or recurrent active systemic infection with bacteremia.
- The patient does not have any of the following:
  - An implanted device that would interfere with the implant of the Micra device in the judgment of the implanting surgeon
  - An implanted inferior vena cava filter
  - A mechanical tricuspid valve
  - An implanted cardiac device providing active cardiac therapy that may interfere with the sensing performance of the Micra device.
- The patient does not have any of the following:
  - A femoral venous anatomy unable to accommodate a 7.8 mm (23 French) introducer sheath
  - Conditions or anatomy that cannot accommodate an implant on the right side of the heart (e.g., due to obstructions or severe tortuosity)
  - Morbid obesity that prevents the implanted device from obtaining telemetry communication within  $\leq 12.5$  cm (4.9 in)
  - Known intolerance to titanium, titanium nitride, parylene C, primer for parylene C, polyether ether ketone, siloxane, nitinol, platinum, iridium, liquid silicone rubber, silicone medical adhesive, and heparin
  - Known sensitivity to contrast media that prevents adequate premedication.
  - Cannot tolerate a single dose of dexamethasone acetate 1.0 mg.

#	YES / NO	Additional comments related to selection criteria for patients who may be medically ineligible for a conventional pacing system
1	Yes	<p>Yes, the patient selection criteria are reasonable with the following caveats and suggested revisions. Criterion 2: The patient has any of the following, which precludes implantation of a single-chamber ventricular pacemaker: Need for persistent anticoagulation therapy</p> <ul style="list-style-type: none"> <li>• Persistent severe bleeding tendencies</li> <li>• Severe lung disease and positive end-expiratory pressure ventilation that precludes internal jugular and subclavian access</li> <li>• Congenitally acquired venous anomalies that preclude transvenous access to the heart</li> </ul> <p>--Comment: We do not think that the first 3 bullets are relevant. In the fourth bullet, we would delete "congenitally acquired" since a leadless pacemaker would be indicated for a venous anomaly of any etiology either congenital or acquired.</p> <p>Criterion 2: Presence of any of the following and delay in implantation of a single-chamber ventricular pacemaker could be life-threatening:</p> <ul style="list-style-type: none"> <li>• Persistent or recurrent local infection at implantation site</li> <li>• Persistent or recurrent active systemic infection with bacteremia.</li> </ul> <p>--Comment: Usually a clinician would try not to implant any permanent device when bacteremia is present. Suggested revision for Criterion 2:</p> <ul style="list-style-type: none"> <li>• Have a history of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are very high risk for infection</li> <li>• Have limited access for transvenous pacing given venous occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an AV fistula for hemodialysis</li> <li>• Have axillary venous access only on a side of the body that would not allow use of a firearm</li> <li>• Presence of a bioprosthetic tricuspid valve</li> </ul>
2	No	<p>Criterion 1: The patient has symptomatic paroxysmal or permanent high-grade arteriovenous block or symptomatic bradycardia-tachycardia syndrome or sinus node dysfunction (sinus bradycardia or sinus pauses).</p> <p>-- Comment: These patients could be considered if the pacing needs are rare. If a patient has high</p>

# YES / NO	Additional comments related to selection criteria for patients who may be medically ineligible for a conventional pacing system
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degree AV block frequently, Micra will result in the loss of AV synchrony.

Criterion 2: The patient has any of the following, which precludes implantation of a single-chamber ventricular pacemaker:

- Need for persistent anticoagulation therapy  
--Comment: This is not a contraindication for a single chamber ppm
  - Persistent severe bleeding tendencies  
--Comment: This would be ok for both technologies.
  - Severe lung disease and positive end-expiratory pressure ventilation that precludes internal jugular and subclavian access  
-- Comment: This is one situation that may favor Micra.
  - Congenitally acquired venous anomalies that preclude transvenous access to the heart
- OR

Presence of any of the following and delay in implantation of a single-chamber ventricular pacemaker could be life-threatening:

- Persistent or recurrent local infection at implantation site
  - Persistent or recurrent active systemic infection with bacteremia.
- Comment: These are all potential Micra options. The patient does not have any of the following:
- An implanted device that would interfere with the implant of the Micra device in the judgment of the implanting surgeon
  - An implanted inferior vena cava filter
  - A mechanical tricuspid valve
  - An implanted cardiac device providing active cardiac therapy that may interfere with the sensing performance of the Micra device.

The patient does not have any of the following:

- A femoral venous anatomy unable to accommodate a 7.8 mm (23 French) introducer sheath
  - Conditions or anatomy that cannot accommodate an implant on the right side of the heart (e.g., due to obstructions or severe tortuosity)
  - Morbid obesity that prevents the implanted device from obtaining telemetry communication within  $\leq 12.5$  cm (4.9 in)
  - Known intolerance to titanium, titanium nitride, parylene C, primer for parylene C, polyether ether ketone, siloxane, nitinol, platinum, iridium, liquid silicone rubber, silicone medical adhesive, and heparin
  - Known sensitivity to contrast media that prevents adequate premedication.
  - Cannot tolerate a single dose of dexamethasone acetate 1.0 mg.
- Comment: These are all reasonable contraindications for Micra

- Based on the evidence and your clinical experience for each of the clinical indications described below:
  - Respond YES or NO for each clinical indication whether the intervention would be expected to provide a clinically meaningful improvement in net health outcome; AND
  - Rate your level of confidence in your YES or NO response using the 1 to 5 scale outlined below.

#	Indications	YES / NO	Low Confidence	Intermediate Confidence	High Confidence	
		1	2	3	4	5
1	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>eligible</u> for a conventional pacing system	Yes				X
	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication	Yes				X

#	Indications	YES / NO	Low Confidence	Intermediate Confidence	High Confidence
	for a ventricular pacing system who are medically <u>ineligible</u> for a conventional pacing system				
2	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>eligible</u> for a conventional pacing system	Yes		X	
	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>ineligible</u> for a conventional pacing system	Yes			X

NR: not reported

- Based on the evidence and your clinical experience for each of the clinical indications described below:
  - Respond YES or NO for each clinical indication whether this intervention is consistent with generally accepted medical practice; AND
  - Rate your level of confidence in your YES or NO response using the 1 to 5 scale outlined below.

#	Indications	YES / NO	Low Confidence	Intermediate Confidence	High Confidence	
		1	2	3	4	5
1	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>eligible</u> for a conventional pacing system	Yes				X
	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>ineligible</u> for a conventional pacing system	Yes				X
2	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>eligible</u> for a conventional pacing system	Yes		X		
	Use of a Micra transcatheter pacing system for an individual with guidelines-based indication for a ventricular pacing system who are medically <u>ineligible</u> for a conventional pacing system	Yes				X

NR: not reported

- Additional narrative rationale or comments regarding clinical pathway and/or any relevant scientific citations (including the PMID) supporting your clinical input on this topic.

#	Additional Comments
1	See above comments.
2	NR

NR: not reported

- Is there any evidence missing from the attached draft review of evidence that demonstrates clinically meaningful improvement in net health outcome?

#	YES / NO	Citations of Missing Evidence
1	Yes	See references in 1a and 1b.
2	No	

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## Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Type of dysrhythmia to be treated
  - Reason for device including but not limited to any contraindications for a standard device (with leads)
  - Type of device requested
  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Prior conservative treatments, duration, and response
- Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
- Laboratory results

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed
- Operative/Procedure report(s)

## Coding

*The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.*

Type	Code	Description
CPT®	33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (e.g., fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed

Type	Code	Description
	33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (e.g., fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed
	0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)
	0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)
	0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
	0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)
	0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component
	0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
	0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial and right ventricular pacemaker components)
	0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component
	0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)

Type	Code	Description
	0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers
HCPCS	None	

## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
10/01/2019	BCBSA Medical Policy adoption
07/01/2023	Policy reactivated. Previously archived from 08/01/2020 to 06/30/2023.
07/01/2024	Annual review. Policy statement, guidelines, and literature review updated.
07/01/2025	Annual review. No changes to policy statement, policy guidelines. Literature review updated.

## Definitions of Decision Determinations

**Healthcare Services:** For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

**Medically Necessary:** Healthcare Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield of California, are: (a) consistent with Blue Shield of California medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the member; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's illness, injury, or disease.

**Investigational or Experimental:** Healthcare Services which do not meet ALL of the following five (5) elements are considered investigational or experimental:

- A. The technology must have final approval from the appropriate government regulatory bodies.
  - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration ("FDA") or any other federal governmental body with authority to regulate the use of the technology.
  - Any approval that is granted as an interim step in the FDA's or any other federal governmental body's regulatory process is not sufficient.
  - The indications for which the technology is approved need not be the same as those which Blue Shield of California is evaluating.
- B. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
  - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

- The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence, or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
- C. The technology must improve the net health outcome.
  - The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- D. The technology must be as beneficial as any established alternatives.
  - The technology should improve the net health outcome as much as, or more than, established alternatives.
- E. The improvement must be attainable outside the investigational setting.
  - When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy Criteria C and D.

## Feedback

Blue Shield of California is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

For medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

*Disclaimer: Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

## Appendix A

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>Leadless Cardiac Pacemakers 2.02.32</p> <p><b>Policy Statement:</b></p> <ol style="list-style-type: none"> <li>I. The Micra™ VR or Aveir™ (see Policy Guidelines) single-chamber transcatheter pacing system may be considered <b>medically necessary</b> in individuals when <b>both</b> conditions below are met: <ol style="list-style-type: none"> <li>A. The individual has high-grade atrioventricular (AV) block (see Policy Guidelines) in the presence of atrial fibrillation or has significant bradycardia and: <ol style="list-style-type: none"> <li>1. Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines)</li> <li>2. Chronic atrial fibrillation</li> <li>3. Severe physical disability (see Policy Guidelines)</li> </ol> </li> <li>B. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as <b>any</b> of the following: <ol style="list-style-type: none"> <li>1. History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection (see Policy Guidelines)</li> <li>2. Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis</li> <li>3. Presence of a bioprosthetic tricuspid valve</li> </ol> </li> </ol> </li> <li>II. The Micra™ AV single-chamber transcatheter pacing system may be considered <b>medically necessary</b> in individuals when <b>both</b> conditions below are met: <ol style="list-style-type: none"> <li>A. The individual has high-grade AV block (see Policy Guidelines) in the presence of atrial fibrillation or has significant bradycardia and: <ol style="list-style-type: none"> <li>1. Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines)</li> </ol> </li> </ol> </li> </ol>	<p>Leadless Cardiac Pacemakers 2.02.32</p> <p><b>Policy Statement:</b></p> <ol style="list-style-type: none"> <li>I. The Micra™ VR or Aveir™ (see Policy Guidelines) single-chamber transcatheter pacing system may be considered <b>medically necessary</b> in individuals when <b>both</b> conditions below are met: <ol style="list-style-type: none"> <li>A. The individual has high-grade atrioventricular (AV) block (see Policy Guidelines) in the presence of atrial fibrillation or has significant bradycardia and: <ol style="list-style-type: none"> <li>1. Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines)</li> <li>2. Chronic atrial fibrillation</li> <li>3. Severe physical disability (see Policy Guidelines)</li> </ol> </li> <li>B. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as <b>any</b> of the following: <ol style="list-style-type: none"> <li>1. History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection (see Policy Guidelines)</li> <li>2. Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis</li> <li>3. Presence of a bioprosthetic tricuspid valve</li> </ol> </li> </ol> </li> <li>II. The Micra™ AV single-chamber transcatheter pacing system may be considered <b>medically necessary</b> in individuals when <b>both</b> conditions below are met: <ol style="list-style-type: none"> <li>A. The individual has high-grade AV block (see Policy Guidelines) in the presence of atrial fibrillation or has significant bradycardia and: <ol style="list-style-type: none"> <li>1. Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest (see Policy Guidelines)</li> </ol> </li> </ol> </li> </ol>

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<ul style="list-style-type: none"> <li>2. Chronic atrial fibrillation</li> <li>3. Severe physical disability (see Policy Guidelines)</li> <li>4. There is an indication for VDD pacing and the individual may benefit from maintenance of AV synchronous ventricular pacing (see Policy Guidelines)</li> <li>B. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as <b>any</b> of the following: <ul style="list-style-type: none"> <li>1. History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection (see Policy Guidelines)</li> <li>2. Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis</li> <li>3. Presence of a bioprosthetic tricuspid valve</li> </ul> </li> <li>III. The Micra™ and Aveir™ single-chamber transcatheter pacing systems are considered <b>investigational</b> in all other situations in which the above criteria are not met.</li> <li>IV. The Aveir™ DR dual-chamber pacing system is considered <b>investigational</b>.</li> </ul>	<ul style="list-style-type: none"> <li>2. Chronic atrial fibrillation</li> <li>3. Severe physical disability (see Policy Guidelines)</li> <li>4. There is an indication for VDD pacing and the individual may benefit from maintenance of AV synchronous ventricular pacing (see Policy Guidelines)</li> <li>B. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as <b>any</b> of the following: <ul style="list-style-type: none"> <li>1. History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection (see Policy Guidelines)</li> <li>2. Limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis</li> <li>3. Presence of a bioprosthetic tricuspid valve</li> </ul> </li> <li>III. The Micra™ and Aveir™ single-chamber transcatheter pacing systems are considered <b>investigational</b> in all other situations in which the above criteria are not met.</li> <li>IV. The Aveir™ DR dual-chamber pacing system is considered <b>investigational</b>.</li> </ul>